Exploring How Nurses' Perceptions of Nurse Managers' Communication Influence their Buy-In to Initiatives to Support Patients' Experiences with Care

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Abstract

Introduction. The continually evolving healthcare environment requires healthcare leaders to better understand how to engage clinicians to support desired organizational change. Nursing remains the dominant profession in U.S. healthcare and nurses are in a unique position to drive change. While much is known about the relationship between nursing practice and patient outcomes, little is known about how the communicative relationships between nurse managers and nurses relate to nurses' engagement in initiatives that support organizational change, in particular those initiatives that support patients' experiences with care.

Aim. To understand how the communicative relationship between nurses and nurse managers relates to nurses' willingness to buy-in to initiatives to support patients' experiences with care.

Design. A qualitative descriptive study was conducted to understand how nurse managers' communication with nurses related to nurses' decisions to buy-in to initiatives to support patients' experiences with care.

Methods. Purposive sampling was used to identify a large Midwestern acute care hospital that had achieved high ratings for patients' experiences with care according to the Centers for Medicare and Medicaid Services's Hospital Consumer Assessment of Healthcare Providers and Systems survey. Once the hospital was identified and hospital nursing leaders engaged, purposive sampling of typical instances was used to identify nurse participants. Data were collected from individual interviews and direct observations. An inductive content analysis approach was used to analyze themes from interview transcripts and observation field notes. Structuration theory was used as a broad framework in which to explore themes that emerged from the data. Methods to support trustworthiness and methodological rigor included credibility, dependability, confirmability, and transferability.

Results. Three themes were identified. The communicative relationship was developed and strengthened through the manager's: (a) use of multiple methods to communicate and influence change, (b) engaging and supporting staff, and (c) promoting staff-led decision making. Findings from this study were used in conjunction with a review of the literature to advise nurse managers on ways in which they may adapt their communication to create an environment in which nurses buy-in to initiatives to support patients' experiences with care.

Conclusion. Strong communicative relationships between nurses and nurse managers positively influenced nurses' willingness to buy-in to and engage in initiatives in support of patients' experiences with care.

Keywords. Communication, communicative behavior, communicative relationship, nurse manager, nurse outcomes, patient outcomes, structuration, trust

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Table of Contents

List of Figures

List of Tables

CHAPTER 1

Introduction

The early twenty-first century brought to the U.S. healthcare system a need to re-envision care of patients. From The Joint Commission and Centers for Medicare and Medicaid Services's (CMS) launch of hospital quality outcomes in 2001, to today's myriad of quality improvement and cost reduction efforts like CMS's value-based quality improvement and cost reduction programs, the healthcare landscape continues to evolve. Also evolving is the complex relationship between Registered Nurses (nurses) and nurse managers (NMs). While nurses serve a critical role to patient outcomes (Aiken, 2014; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Dunton, Gajewski, Klaus, & Pierson, 2007), nurses' dissatisfaction with their work environment, a setting in which NMs play a pivotal role, can have a detrimental impact on the patient experience (Aiken et al., 2012).

Nurse managers are critical to the nurse's work experience (Faulkner & Laschinger, 2008). Although relationship factors such as authenticity, empowerment, trust, and personal connection have been addressed in the literature (Cziraki & Laschinger, 2015; Fallatah, Laschinger, & Read, 2017; French-Bravo & Crow, 2015), understanding how communicative relationships (i.e., the resulting relationship from the negotiation between two or more people of both the interpretation and meaning of information; Koschmann, 2016) between nurses and NMs relate to nurses' buy-in to organizational initiatives has not been thoroughly researched. Research in this area will offer new insights into how nurses' perceptions of their relationships with NMs may influence organizational outcomes including financial performance; quality, safe patient care; and employee-related outcomes such as turnover and retention.

Statement of the Problem and Significance

Healthcare leaders must understand and address the complex relationships among healthcare institutions, patients, clinicians, and payers within an evolving landscape of healthcare reform. The Institute for Healthcare Improvement's (IHI) 2007 Triple Aim framework serves as roadmap for healthcare system reform in the United States (Berwick, Nolan, & Whittington, 2008). The Triple Aim includes three domains: improving the patient experience (satisfaction and quality), improving the health of populations, and reducing the per-capita cost of healthcare. Bodenheimer and Sinsky (2014) proposed an expansion to a Quadruple Aim, adding the goal of improving clinicians' experience of providing care. Although not yet formally adopted by the IHI, the Quadruple Aim has been adopted by hospitals throughout the United States as leaders recognize that the Triple Aim cannot be achieved without the support of healthcare clinicians (Sikka, Morath, & Leape, 2015).

As healthcare organizations evolve to support quality care at an affordable price, they also must also evolve to support clinicians who perform the work of the organization. Ruddy, Thomas-Hemak, and Meade (2016) explained that in addition to transforming technical processes, the process of "transforming people can be fundamentally disorienting, emotionally painful, and thoroughly exhausting" (p. 625). Still, to transform a system, a culture, and the healthcare industry, healthcare leaders and clinicians must focus on both process and culture changes. To date, there has been much talk about the need to create environments supportive of clinicians. Relatively few actions have been taken toward this goal, in part because of the intricacies associated with transforming institutional cultures.

Cultural transformation requires an intimate understanding of the people who comprise the culture, including their interactions and their interrelatedness. Ruddy, Thomas-Hemak, and

Meade (2016) precisely articulated the pivotal relationship between each member of the organization and the organization's desired cultural transformation. Each member of an organization brings a worldview that serves as his or her foundation of knowing and conversations among members continually shape their worldviews. Cultural transformation occurs as members of an organization transition to a shared worldview that supports the organization's outcomes. An organization must focus on creating an environment in which a shared worldview among clinicians means they are not only willing to buy-in to organizational initiatives, but also take professional ownership in the success of those initiatives.

Given that nursing remains the dominant profession within U.S. hospitals, a granular focus on the environment in which the practice of nursing occurs may help leaders better understand how a shared nursing worldview can support organizational outcomes. Of the 8,315,500 healthcare clinicians employed in the United States in 2016, 56.04% were employed in general medical and surgical hospitals. Within the hospital setting, nurses represented 30.49% of the workforce, or 1,649,480 professionals, more than any other group of hospital employees (U.S. Department of Labor, Bureau of Labor Statistics, 2016). The Institute of Medicine's (IOM, 2011) *Future of Nursing* report highlighted the critical role nurses play in leading healthcare reform. The report included a number of key messages and recommendations, one of which called for nurses to collaborate with others in healthcare to shape how the provision of patient care will look in the United States. Within these collaborative partnerships is the need for nurses to be accountable for their own contributions, as well as the need for leaders within the organization to understand how their role as leader influences nurses.

One consideration in implementing the IOM's recommendations is an organizational understanding of the environment in which nurses work and how that environment influences

outcomes. For example, it has been suggested that the link between patient experience and nurse engagement is such that nurses' experiences of providing care influence how patients perceive their experience with care (Laskowski-Jones, 2016). Nurses who believe their work environment is unsupportive of their role within the organization are less likely to be engaged and less likely to have a positive experience of providing care (Smith Lewis & Cunningham, 2016; Van Bogaert et al., 2017). The influence of a leader's management style on a nurse's level of engagement in the work environment is well studied (Manning, 2016; Smith Lewis & Cunningham, 2016). Understanding how the NM's communication relates to nurse engagement in initiatives to enhance patients' experiences with care (PEC) would fill an important gap in the literature as it relates to the Quadruple Aim.

The phrase 'patients' experiences with care' is used throughout this chapter as it is how the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, the instrument described in Manuscript 2, identified patients' perceptions of their care. Additionally, "outcomes" is used broadly throughout this chapter, with nurse outcomes referring to nursing-related workforce indicators (e.g., nurses' experiences of providing care, turnover, engagement, burnout, and trust) and patient outcomes referring to patient-related quality of care indicators influenced by nursing practice (e.g., PEC, hospital acquired infections, and safety; Jones, 2016).

Literature Review

If organizations are to thrive in an environment that supports PEC and clinicians' experiences of providing care, then leaders will benefit from understanding how their communicative relationships influence organizational outcomes. A review of the literature was conducted to: (a) examine nurse trust in the NM as an inherent factor driving organizational change, (b) explore how NMs' communication relates to nurse outcomes, (c) identify

relationships between the nurse work environment and patient outcomes, and (d) examine factors that influence nurse buy-in to organizational initiatives.

Nurse Trust in Nurse Manager

Nurses' commitment to the organization and the organization's initiatives is driven in part by trust, particularly trust in their NMs (McCabe & Sambrook, 2014). Trust is defined as an allowance of vulnerability by an individual, the trustee, to the acts of another, the trustor, with the understanding that the trustor is acting in the best interest of the trustee (Mayer, Davis, & Schoorman, 1995). A NM, also referred to as clinical coordinator, supervisor, or director, is a leader who has accountability for the operation of one or more clinical units and to whom those who work in the unit report (Schmalenberg & Kramer, 2009). Within healthcare in general and nursing in particular, trust is a foundational organizational factor that must be present to drive effective, sustainable change (Spence Laschinger, Finegan, & Shamian, 2001).

A leader's influence has a profound effect on a subordinate's trust in that leader. An individual's personal leadership style is highly influential in forming a trusting relationship (Bobbio, Bellan, & Manganelli, 2012; Dirks & Ferrin, 2002; McCabe & Sambrook, 2014; Spence Laschinger et al., 2001). Bobbio et al. (2012) surveyed 273 nurses in a hospital in Italy to ascertain the relationship between nurses' perceptions of their NM's leadership style and perceived organizational support, trust in manager, and trust in the organization. Leadership styles that were significantly associated with trust in manager included: participative decision making, coaching, informing, and showing concern and interacting with the team.

McCabe and Sambrook (2014) concluded in their qualitative study of 28 nurses and 11 NMs that NMs in the immediate work environment who led by example were more likely to elicit the trust of others. Spence Laschinger et al.'s (2001) findings supported an empowerment

leadership approach to gaining trust. The purpose of their study was to test a model that linked staff nurses' workplace empowerment, organizational trust, job satisfaction, and organizational commitment. Based on survey responses from 412 nurses working in tertiary care hospitals in Canada, empowerment was positively associated with trust in a model with job satisfaction as the outcome variable and in a proposed model with affective commitment as the outcome variable.

Nurse trust in NM is an important factor to consider when exploring nurses' buy-in to organizational initiatives. Leading by example and allowing nurses to participate in decision making are two ways in which NMs build trust with nurses. Exploring how nurses describe the relationship of trust with their NM may be useful to understanding nurses' buy-in to initiatives to enhance PEC.

Relationship of Nurse Manager Communicative Behaviors to Nurse Outcomes

Just as trusting relationships are important to organizational outcomes, so, too, are communication and communicative behaviors. Communication is broadly defined as "a process through which people, acting together, create, sustain, and manage meanings through the use of verbal and nonverbal signs and symbols within a particular context" (Conrad & Poole, 2012, p. 5). A communicative behavior is an expression of communication and is defined as an action by one person that stimulates a second person (Smith, 1946). A verbal conversation is an example of a communicative behavior, as is tone of voice, facial features, and body language of the speaker. Composition of written communication, like the use of all capital letters in an email or multiple exclamation marks in written communication, is also a communicative behavior. Other examples of communicative behaviors as interpreted by the listener include the presence and

absence of trust, confidentiality, respect, admiration, encouragement, compassion, situational awareness, and understanding.

Bodenheimer and Sinksy's (2014) recommendation that a component of healthcare transformation include careful attention to improving clinicians' experiences of providing care aligns with research that has been conducted in nursing to better understand the relationship of NM communicative behaviors to nurse outcomes such as nurse job satisfaction and nurse engagement. Feather, Ebright, and Bakas (2015) conducted focus groups using semi-structured interviews to assess 28 U.S. nurses' perceptions of NMs' behaviors that influence nurses' job satisfaction. Nurses wanted managers who were consistent in both words and actions, who actively listened, who promoted open discussion, and who maintained confidentiality, a key research finding centered on communication. Other key themes that influenced nurses' job satisfaction were respect, feeling cared for, and NMs' ability to relate to the work performed by nurses on the unit.

Kunie, Kawakami, Shimazu, Yonekura, and Miyamoto's (2017) cross-sectional survey of 906 Japanese nurses explored the relationship between NMs' communication behaviors toward nurses and nurses' work engagement and psychological stress. Nurses' work engagement increased when nurses perceived their managers to use motivational language. The researchers' findings aligned with McCabe and Sambrook's (2014) assessment of nurses' trust in NMs as a key component of nurses' commitment to the organization.

Additional research outside of the United States has evaluated the communicative relationships between nurse and NM. Rouse and Al-Maqbali (2014) employed a qualitative and quantitative study design to understand NMs' communication from the perspectives of 1,526 hospital nurses working in Oman. Nurses reported more dissatisfaction and felt less respected in

their work environment when NMs' communication was focused on mistakes and was not expressive of appreciation of good work. From Wagner, Bezuidenhout, and Roos' (2014) analysis of questionnaires collected from 265 nurses working in public hospitals in South Africa, nurses perceived the flow of information between nurse and NM to be inadequate, creating an environment in which nurses felt as if they were not listened to nor paid attention to.

Portoghese et al. (2012) used a predictive, nonexperimental study design with a random sampling of 395 nurses in Italy to analyze the influence of leadership and communication on nurses' commitment to change. Nurses' expectations specific to organizational change were related to how the NM communicated that change. Specifically, NMs had the capacity to create within the nurses they led either positive or negative expectations of organizational change simply by how they communicated that change. If NMs communicated poorly about a planned change, nurses perceived the change poorly. Likewise, if NMs communicated positively about the planned change, nurses perceived the change positively.

Communication between nurse and NM is an important component to nurse outcomes. Nurses were more satisfied with their work and assessed change more positively when NMs communicated effectively. While international studies exist, a gap in the literature remains specific to the influence of communicative relationships between NM and nurse as perceived by nurses in U.S. hospitals. Healthcare leaders may benefit from understanding the communicative relationships between nurses and NMs before beginning a change initiative as that relationship may influence the success of the initiative.

Relationship Between Nurse Work Environment and Patient Outcomes

Both trusting and communicative relationships influence the environment in which care is performed. Aiken et al. (2012) highlighted the influence of the work environment on patient

outcomes in their cross-sectional survey of nurses and patients in the United States and Europe. Of the 21,001 U.S. nurses surveyed, 34% believed themselves to be burnt out and 14% intended to leave their job in the next year. Patients receiving care in work environments with higher levels of nurses experiencing burnout were less likely to rate their hospital highly (95% CI [0.91, 0.96]), compared to patients receiving care in work environments with higher levels of nurses who intended to leave in the next year (95% CI [0.89, 0.95]).

According to a qualitative analysis of interviews from 26 Dutch nurses, work environment factors including adequate staffing, a patient-centered care approach, nurse control over nursing practice, clinical competency, support of management, and collaborative relationships were identified as contributors to patients' positive experiences with care (Kieft, de Brouwer, Francke, & Delnoij, 2014). Boev (2012) conducted a secondary data analysis of 671 nurse work environment surveys and 1,532 patient satisfaction surveys from four adult ICUs in a large east coast teaching hospital. ICUs in which nurses described a favorable perception of their NM also experienced favorable patient satisfaction.

The nurse work environment does contribute to patient satisfaction. The review of the literature identified that patients were less likely to rate the hospital favorably in environments with higher levels of nurse burnout and intent to leave. Likewise, patients were more satisfied in environments where nurses felt they had control over their practice, were supported by their managers, and had adequate staffing. The nurse work environment is an important consideration when identifying opportunities and barriers to enhance PEC.

State of the Science

The nurse work environment influences both nurse and patient outcomes. NMs have the capacity to positively influence the work environment in support of desired organizational

outcomes, yet there is a dearth of research in identifying specific factors that influence nurses' buy-in to organizational initiatives, including how the communicative relationship between nurse and NM relates to PEC in U.S. hospitals. The purpose of this study was to: (a) understand how the process of structuration through discourse may support an environment in which nurses want to buy-in to organizational initiatives that support PEC; (b) understand how nurses' perceptions of their NMs' communication relates to their buy-in to hospital initiatives to support PEC, and (c) use the findings to provide recommendations to NMs as to how they can positively influence PEC through communication with nurses they lead.

Research Questions

Three research questions guided this dissertation:

1. How can the process of structuration through discourse support nurse buy-in to initiatives that support PEC?
2. Using the perspective of structuration, how do nurses' perceptions of communication with their NM relate to nurses' willingness to buy-in to organizational initiatives to enhance PEC?
3. What steps can NMs take to influence how nurses positively perceive their communication?

Purpose, Scope, and Methods for Manuscripts

This dissertation's research questions were explored and reported through a series of three manuscripts. Each manuscript's purpose, scope, and method are outlined below**.**

Manuscript 1: Structuration as a Foundation of Nurse Buy-In to Organizational Initiatives

Purpose

The purpose of this manuscript was to explore how structuration through discourse continually shapes nurse buy-in to organizational initiatives.

Methods

The importance of successful nursing initiatives in an environment of continual change in healthcare was reviewed. Anthony Giddens's (1984) structuration theory was analyzed and key concepts defined, including agents, agency, and structure. Within a framework of structuration, individuals shape social systems through intentional and unintentional actions taken in response to rules and resources. Those rules and resources continually evolve through organizational discourse. French-Bravo and Crow's (2015) factors influencing buy-in were reviewed to establish antecedents for nurse buy-in to organizational change initiatives. An analysis of the literature was offered to establish the relationship of nurse buy-in and NM discourse to complex organizational change. An exemplar was provided to describe how managers' attunement to the conversations that create the social system in which nurses practice, independent of how managers believe policies and procedures should be actualized, better positions managers to support desired organizational change.

Manuscript 2: The Importance of Nurse Manager Communication in Understanding Nurse Buy-In to Initiatives that Enhance Patients' Experiences with Care

Purpose

The purpose of this qualitative descriptive study was to understand how NMs' communication with nurses related to nurses' decisions to buy-in to organizational initiatives. This study used the perspective of structuration (Manuscript 1) to explore hospital-based nurses'

willingness to buy-in to initiatives to enhance PEC as a function of their perception of NMs' communication. Giddens's (1984) structuration theory was used as a broad framework for exploration, not for theoretical testing, but rather to facilitate the exploration of themes emerging from the data.

Philosophical Framework

This qualitative descriptive study was broadly supported by a paradigm of naturalistic inquiry underpinned by a position of ontological realism and epistemological constructionism. A key ontological assumption in this study was that meaning (values, intentions, beliefs) hold equal weight to physical phenomena in explaining social phenomena. In other words, meaning is part of reality rather than separate from it (Maxwell, 2011). The process of understanding from a constructionist perspective is a result of the collective interactions of individuals within relationships (Gergen, 1985). Reality is structured by and through the interactions (in both meaning and actions) of others (Giddens, 1984).

Constructionism and constructivism are not consistently differentiated in the literature, yet their distinctions are important for understanding the conceptual underpinnings of this study. Gergen (1985) in his early work acknowledged that constructionism and constructivism were both synonymous with the movement of social constructionism he described. Guba and Lincoln (1994) noted they had previously referred to constructivism as naturalistic inquiry. For this study, constructionism is generally understood to be meaning-making within *relationships* and constructivism is meaning-making within the *individual* (Mills, Birks, & Hoare, 2014).

Examining nurses' willingness to buy-in to initiatives to enhance PEC as a function of their relationship with their NM is an exploration into communicative behaviors, including both physical acts of communication and acts of meaning inferred from communication. A nurse's

reality is socially constructed in part by interactions with his or her NM. Reality also is socially constructed through interactions with others. Although social constructionists often use a grounded theory approach (Charmaz, 2008), the study used a broader qualitative descriptive approach aligned with tenets of naturalistic inquiry (Sandelowski, 2000). The qualitative descriptive approach facilitated as much as an unfiltered view of the nurse's reality as one could achieve, while recognizing that the interaction of the researcher and the study participant is a relationship in and of itself, and thus was carefully scrutinized during all stages of research.

Methods

Design. The study employed an exploratory qualitative descriptive design. The qualitative descriptive method was used because of the sparsity of research related to the study question, thus enabling the voice of the participant as primary interpreter of the perception of NM communication. Sandelowski (2000) cautioned although the qualitative descriptive method is the least theoretical of qualitative study designs, it is not void of a researcher's philosophical underpinnings, nor is it necessarily void of the essence of other approaches (Sandelowski, 2010) such as core components of structuration that may enhance exploration and interpretation of data (Giddens, 1984).

The researcher's constructionist paradigm was a constant companion throughout all phases of the research process insomuch as "the researcher and researched coconstruct the data – data are a *product* of the research process, not simply observed objects of it" (Charmaz, 2008, p. 402). Additionally, qualitative description was a suitable method for this study as it aligns with the constructionist paradigm in that qualitative description allows for as much of an unfiltered interpretation of the nurse's perception, and thus his or her reality, of his or her NM's communication as possible.

Sample and setting. This study used purposive sampling of typical instances to identify one large acute care hospital in a Midwestern urban metropolitan area that had achieved a four or five-star summary rating for PEC. The summary star rating is identified by CMS's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey reported April 1, 2016 through March 31, 2017. The HCAHPS survey is the first publicly reported, standardized tool to assess how patients hospitalized throughout the United States perceive their hospital care (CMS, 2017a). The data are publicly reported to allow comparisons across hospitals at local, regional, and national levels. Four and five-star summary ratings for PEC were key inclusionary criteria because they reflect a hospital's overall focus on ensuring hospitalized patients positively perceive their care. Because the purpose of this study was to understand how nurses' perceptions of their NMs' communication related to their buy-in to hospital initiatives to support PEC, only hospitals that received a 4 or 5 star rating were considered for inclusion. In December 2017, 43% of the 3,419 hospitals nationally that publicly reported HCAHPS scores had a four or five-star summary rating (CMS, 2017b).

The HCAHPS survey is administered to a random sample of patients 18 years of age or older 48 hours to six weeks post-discharge from acute care medical, surgical, and maternity care units (CMS, 2017a). Acute care hospitals participating in Medicare's Part A Inpatient Prospective Payment System (IPPS) must collect and submit a minimum of 300 completed surveys to receive their full annual Medicare payment update. A hospital's HCAHPS performance is also included in the calculations for value-based incentive payments in the Hospital Value-Based Purchasing program. For hospitals that voluntarily participate in HCAHPS, like smaller critical access hospitals, a minimum of 25 completed surveys over a four-quarter period are required for public reporting. To receive star ratings, participating hospitals

must have a minimum of 100 completed surveys over a four-quarter period. In July 2017, 4,315 hospitals reported scores, representing more than 3.1 million completed surveys.

Shadish, Cook, and Campbell (2002) described purposive sampling of typical instances as a useful sampling approach to generalize to a particular setting, in this case large acute care hospitals with high summary ratings for PEC. Acute care hospitals are defined by CMS (n.d.) as providing inpatient medical care for injuries, medical conditions, or surgeries for short-term conditions. Large acute care hospitals are defined as those hospitals with greater than 1,000 completed surveys during the designated reporting period. A large acute care hospital was included in this study because of the researcher's professional experience working in large acute care hospitals and desire to better understand how NMs' communication with nurses related to nurses' decisions to buy-in to initiatives to support PEC in the large acute care hospital setting. In addition, the number of nurses employed the large acute care hospitals facilitated an adequate sample size.

The Midwestern urban metropolitan setting comprised 14 counties in two states and had an estimated population of 2.10 million people (U.S. Department of Commerce, 2017). Within the urban metropolitan were 11 hospitals that had achieved a four or five-star summary rating for PEC, three of which were classified as large acute care hospitals. The four-star hospital with the largest number of completed surveys was invited to participate since there were no large acute care hospitals with a five-star summary rating.

The researcher contacted the hospital's Chief Nursing Officer (CNO) via phone to introduce himself, briefly introduce the research plan, and request a Skype meeting to provide further details and invite the hospital to participate in the study. The same information was introduced and meeting requested via email as well (see Appendix A). See Appendix B for

email communication between the hospital's CNO and this researcher, confirming the CNO's interest in the study and the hospital's willingness to participate.

Once the CNO confirmed her willingness to participate, she was asked to provide the name, phone number, and email address of each NM who led medical and/or surgical units within the hospital. Each identified NM was contacted and information provided (see Appendix C) using the same approach used to engage the hospital's CNO.

With the NM engaged, participants were recruited using a purposive, nonprobability, voluntary sampling strategy as described by Patton (2015). In this approach, each medical or surgical unit NM was asked to email (see Appendix D) a letter of invitation (see Appendix E) to all eligible unit nurses. The letter of invitation included study purpose, anticipated one-hour time commitment, researcher's contact information, assurance of confidentiality, and inclusion and exclusion criteria. The NM was asked to notify the researcher once when she transmitted the emails. Nurses who self-identified as meeting inclusion criteria were encouraged to contact the researcher should he or she wish to participate.

The NM was contacted via phone and email once weekly until confirmation was received that the letter of invitation had been emailed to unit nurses. The NM was asked to email all unit nurses one study reminder per week for a period of four weeks. The researcher prompted the unit manager to send the study reminder by emailing the unit manager each week.

Nurse participant inclusion criteria included: (1) a minimum of three months of work experience on the medical and/or surgical units from which the nurse was selected; (2) full or part-time employment status as defined by the hospital (no less than 20 worked hours per week on average); and (3) 50% or greater of worked time spent in direct patient care. Nurse exclusion criteria included: (1) nurses new to the organization or who transferred from another unit within

the hospital less than three months prior to interview, (2) direct care nurses who were identified as the charge nurse or who had full-time supervisory responsibilities over direct care nurses, (3) nurses who worked in areas to which HCAHPS scores were not attributed, and (4) refusal to provide consent. While the NM initially identified inclusion and exclusion criteria, the researcher confirmed with each nurse his or her eligibility to participate. Charge or supervisory nurses were excluded because factors such as formal charge nurse training and ongoing leadership development opportunities may bias their perception of NM communication (Sherman, Schwarzkopf, & Kiger, 2011).

The researcher continued to build the sample until saturation was reached. Saturation depends on study scope, data quality, phenomenon of concern, and the quality of useful data obtained from each interviewee (Morse, 2000). Feather, Ebright, and Bakas's (2015) qualitative work included a sample size of 28 nurses within 5 focus groups and was used as an estimate for sample size in this study. Twelve to 18 nurses were estimated as needed to reach saturation.

Data collection. The study commenced after Institutional Review Board (IRB) approval in July 2018. Data were collected in-person at a location and time of the participant's choosing or via phone using a semi-structured interview guide (see Appendix F). While phone interviews differ from in-person interviews in that non-verbal behaviors are not observable, phone interviews were included to assure feasibility of the study. The semi-structured interview approach was used with purposeful, open-ended questions designed to generate meaningful responses without leading the participant to a certain response (Usher & Jackson, 2014). The use of a semi-structured interview guide is an excellent approach to better understanding the lived experience of others (Krauss, 2005) and aligns with tenets of qualitative descriptive design (Sandelowski, 2000).

Participants were asked to provide demographic data including age, ethnicity, gender, tenure, and level of education at the beginning of each interview in order to describe the sample (see Appendix G). Participants were encouraged to select an interview location free from distractions or interruptions that was conducive to open and honest sharing and supported confidentiality to the level expected by the interviewee. For phone interviews, the researcher ensured confidentiality by selecting a private location in which to conduct the interview. Interviews continued until saturation was reached. Informed consent was obtained from each study participant by the researcher before data collection (see Appendix H). For in-person interviews, the researcher presented the participant with a copy of the informed consent. For phone interviews, participants were emailed a copy of the informed consent and were asked to sign and return electronically (via scanned image or photo image) before the phone interview. Participants were encouraged to ask questions and seek clarification.

Interviews were anticipated to take approximately one hour and were audio recorded for later transcription using both a primary and backup audio recording device to ensure no loss of data. For phone interviews, the researcher used his phone's speaker to amplify the participant's words so that both researcher and participant words were captured using primary and backup audio recording devices. Audio recording provides the most accurate summary of participant-researcher dialogue (Morgan & Guevara, 2008). The researcher conducted each interview. A professional transcriptionist with experience in transcribing qualitative interviews was hired to transcribe each interview. Audio files were transmitted electronically using a secure file sharing system. The researcher carefully compared each transcribed interview with the original audio file to ensure accurate transcription.

Data were also collected via observation with documentation of field notes, both important adjuncts to the interview process (Mills, 2014). Although one cannot directly visualize the perception of another, visual cues during nurse-NM interactions were assessed to further reinforce themes derived from participants' interviews. The researcher sought permission from the CNO to attend medical or surgical unit staff meetings after study commencement. The researcher acted as observer only, documenting observations of interactions between the NM and nurse participants in the meeting. The number of staff meetings attended depended on the level of engagement among meeting participants. The researcher introduced himself during each staff meeting, informing attendees of the purpose of his presence and how data would be used (see Appendix I). Additional relevant artifacts such as policies, procedures, strategic plans, emails, fliers, and/or other communication were also collected.

Data Analysis

Elo and Kyngas's (2008) conventional inductive content analysis approach was used to analyze data. Sandelowski (2000) and Hsieh and Shannon (2005) argued the value of a conventional inductive approach to a qualitative descriptive study. In the conventional approach, data are not forced into a pre-determined category; subsequently, analysis best reflects the phenomenon of concern as described by participants and is undertaken with both an iterative and recursive mindset (Colorafi & Evans, 2016). The researcher performed all aspects of data analysis after ensuring the transcripts accurately reflected participants' words. The first step was to read and then re-read each transcript, not approaching the data with intent to find themes or commonalities, but rather approaching each story with a sense of curiosity. The second step was to perform open codification by again reading each transcript line-by-line, highlighting words or phrases that may be significant, and then noting in the margins why the highlighted words or

phrases may be important. The third step of data analysis was to read the transcript again, ruminating on the highlighted words or phrases and contemplating additional important words or phrases that did not appear during the first read.

The next phase of analysis was to take important words or phrases found while reading each transcript and transfer those words or phrases to a coding sheet, assigning them as condensed meaning units. Each condensed meaning unit was further analyzed and condensed to short words or phrases that were then categorized as codes. The final phase of data analysis, abstraction, involved grouping like codes together into general categories, grouping general categories into main categories or themes, and creating definitions for each. Abstraction continued until all pertinent data are categorized and defined.

Trustworthiness and Methodological Rigor

This study used Lincoln and Guba's (1985) criteria (i.e., credibility, dependability, confirmability, and transferability) to ensure methodological rigor and promote trustworthiness. Triangulation of multiple sources (e.g., interviews and observations) was used to support credibility and confirmability. Credibility was also established via member-checking, a process in which each participant was provided a verbal synopsis of the conversation before the end of the interview session and encouraged to verbalize changes. Peer debriefing with dissertation co-chairs was used to illuminate potential bias and offer challenging or alternate interpretations. Dependability was supported through careful note taking to provide an audit trail. Lincoln and Guba described reflexive journaling as a technique that can apply to all four areas of methodological rigor. For this study, components of the reflexive journal included daily schedules, a personal diary providing an opportunity for the researcher's reflection on how his personal values and knowledge may be influenced by and influence the research process, and a

methodological log in which decisions about processes were noted. Finally, providing a rich description of results supported transferability of findings.

Ethical Considerations

Approval from the Human Subjects Committee, the designated Institutional Review Board (IRB) for a Midwestern academic medical center, was obtained before study commencement. The participant letter of invitation included a section stating that participant confidentiality would be maintained through use of pseudonyms and results would be aggregated at the unit level. The participants' NMs were not provided a list of nurses who had agreed to participate. Participants were assured that they could withdraw their participation at any time, for any reason, without their NM being notified by the researcher; without ramifications to their employment; and without impact on their ability to receive care at the hospital in which they were employed. Demographic data collected were reported as aggregated data and pseudonyms were used in place of participant names to protect anonymity.

Research records including audio recordings, demographic data, and de-identified transcripts were temporarily stored on the researcher's password protected computer and then transferred to a KUMC secure server. Electronic transmission of audio recordings, demographic data, or de-identified transcripts was done using a secure file sharing system. Field notes, reflexive journal, and any other non-electronic records were stored in a locked file cabinet. Research records will be destroyed after seven years in accordance with KUMC Research Institute, Inc.'s Research Record Management, Disposition and Retention Policy.

Strengths and Limitations

A key strength to the exploratory qualitative descriptive study design is its capacity to better understand how a nurse's perception of NM communication relates to his or her

willingness to buy-in to initiatives to enhance PEC. However, several potential, critical barriers were assessed before study commencement. First, access to nurses could have been problematic. Without the support of the CNO, the research could not continue. If the CNO was not receptive, a similar hospital setting would have been considered and that CNO approached. Another potential barrier was the NMs' responsiveness to the researcher's initial communication and their willingness to email study information to eligible nurses. Should the NM not have responded after a follow-up email to the initial request, the CNO would have been consulted for next steps. Finally, Rimando et al.'s (2015) recommendations for reducing researcher fatigue were used, including limiting the number of interviews to four per day, taking a break between interviews, and debriefing with a colleague at the end of an interview day if one was available.

Manuscript 3: The Power of Communication: The Nurse Manager's Capacity to Influence the Environment in which Patients Experience Care through Communication with Nurses

Purpose

The purpose of this manuscript was two-fold. First, to review and synthesize the literature to identify how the role of hospital-based NMs' communicative relationships with nurses related to PEC. Second, to use findings from the qualitative descriptive study (Manuscript 2) to craft recommendations for how hospital-based NMs can positively influence nurses' perceptions of NM communication. Two research questions were proposed:

1. Based on a review and synthesis of the literature, what information exists that identifies how a hospital-based NM's communicative relationships with nurses relate to PEC?
2. Based on the findings of Manuscript 2, what actions can hospital-based NMs implement so that nurses more positively perceive NMs' communication?

Methods

A review and synthesis of the literature was conducted to identify how NMs' communicative relationships with nurses related to PEC. Electronic searches were performed in PubMed, CINAHL, and ProQuest for studies published between January 2009 and March 2019. Internet searches using Google and Google Scholar were also conducted. A combination of keywords and phrases were included using the "AND" and "OR" operators: manager, leader, communication, discourse, patient satisfaction, and patient experience. Both peer and non-peer reviewed publications, including grey literature, expert commentaries, popular press magazines, and blogs, were considered for inclusion. Non-peer reviewed publications were considered because of the sparsity of peer-reviewed publications specific to the first research question. Articles were considered for inclusion if they addressed a relationship (whether anecdotal or researched) between NM communication with nurses and PEC. Articles were excluded if the setting was not identified as hospital-based or if the patient population was non-adult. An analysis of the level of evidence was included. Recommendations for specific actions NMs should take so that nurses better perceive NMs' communication, informed from the literature synthesis and findings from Manuscript 2, were offered.

Assumptions

The researcher for this dissertation made the following assumptions:

1. Communication can influence outcomes.
2. Nurse managers have the capacity to adapt their communication style.
3. Nurses have the capacity to adapt their perception of NM communication.
4. Nurses' buy-in to initiatives to enhance PEC can positively influence how patients perceive the care experience.

5. Patients' perceptions vary and the provision of care is multifactorial. Even when conditions exist in which nurses positively perceive communication from NMs and buy-in to initiatives to enhance PEC, patient survey results may not always reflect a positive experience with care.
6. Participants will be honest about how they perceive communication they receive from their NMs.
7. Participants will be able to describe hospital initiatives that they believe influence PEC.
8. Participants' verbal and non-verbal communication will not be significantly influenced by the presence of the researcher during observations.

Definition of Terms

The following terms were used for the purpose of this dissertation:

Buy-in: "the act of an individual or group giving something in return for something else" (French-Bravo & Crow, 2015, "What Buy-In Means," para. 1).

Communication: "a process through which people, acting together, create, sustain, and manage meanings through the use of verbal and nonverbal signs and symbols within a particular context" (Conrad & Poole, 2010, p. 5).

Communicative behavior: an action by one person that stimulates a second person (Smith, 1946).

Nurse manager: a leader, also referred to as clinical coordinator, supervisor, or director, who has accountability for the operation of one or more clinical units and to whom those who work in the unit report (Schmalenberg & Kramer, 2009).

Nurse outcomes: nursing-related workforce indicators (e.g., nurse satisfaction, turnover, engagement, burnout, and trust; Jones, 2016).

Patient outcomes: patient-related quality of care indicators influenced by nursing practice (e.g., patient satisfaction, hospital acquired infections, and safety; Jones, 2016).

Structuration: the shaping of social systems by individuals through their intentional and unintentional actions taken in response to rules and resources (Giddens, 1984)**.**

Trust: an allowance of vulnerability by an individual, the trustee, to the acts of another, the trustor, with the understanding that the trustor is acting in the best interest of the trustee (Mayer, Davis, & Schoorman, 1995).

Summary

The evolving landscape of U.S. healthcare demands a new look at processes and functions within hospitals. Lack of nurse engagement resulting in decreased buy-in to organizational initiatives is a consequence of an ineffective work environment (Boev, 2012; Smith Lewis & Cunningham, 2016; Van Bogaert et al., 2017). The impetus for this dissertation was a lack of substantive data demonstrating how NMs' communication with nurses, a component of the work environment, influences nurses' decisions to buy-in to organizational initiatives. Chapter 1 identified the problem and significance. Based on a review of the literature, three investigations (comprising three separate manuscripts) were conducted that collectively serve to further the understanding of the influence of the communicative relationship between NM and nurse on nurse buy-in to organizational initiatives, specifically those initiatives that positively influence PEC.

Manuscript 1 was a review of how the process of structuration through discourse supports nurse buy-in to initiatives in support of PEC. The review concluded with an exemplar demonstrating how managers could position themselves to support desired organizational change through an awareness of how conversations within organizations create social systems that drive

change. Manuscript 2 used a qualitative descriptive study to explore how NMs' communication with nurses related to nurses' buy-in to initiatives that supported PEC. Nurses from acute care hospitals that had achieved high ratings for PEC were interviewed and direct observations conducted. Structuration theory (Manuscript 1) was used as a broad framework to explore themes that emerged from the data.

Manuscript 3 included a review of the literature to identify the role of NMs' communicative relationships with nurses to PEC. Findings from the literature review and themes from the descriptive study (Manuscript 2) were used to offer recommendations for how NMs can positively influence how nurses perceive their communication. Results from this collective study add to the body of nursing knowledge on the influence of NM communication on outcomes, an important addition to nursing knowledge given the ongoing need to transform healthcare in support of quality, safe patient care in a work environment conducive to nurses and other clinicians (Berwick et al., 2008; Bodenheimer & Sinsky, 2014).

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CHAPTER 2

Structuration as a Foundation of Nurse Buy-In to Organizational Initiatives

Abstract

The purpose of this manuscript is to explore how structuration through discourse serves as a foundation to nurse buy-in to organizational initiatives. The importance of successful nursing initiatives in an environment of continual change in healthcare was reviewed. French-Bravo and Crow's (2015) factors influencing buy-in were reviewed to establish antecedents for nurse buy-in to organizational change initiatives. An analysis of the literature was offered to establish the relationship between discourse and complex organizational change. Anthony Giddens's (1984) Structuration Theory was analyzed and key concepts defined, including agents, agency, and structure. A scenario was offered to demonstrate structuration in action. When leaders are attuned to how conversations create the social system in which nurses practice, independent of how they believe policies and procedures should be actualized, leaders will be in a better position to support desired organizational change.

Keywords: structuration, buy-in, discourse, communication, organizational change

Issue

The previous twenty years have been pivotal in shaping the state of healthcare as it is experienced by patients and clinicians in the United States today. The turn of the twenty-first century brought with it a renewed focus on quality and cost of healthcare. In 2001, the Centers for Medicare and Medicaid Services (CMS, n.d.) launched several hospital quality outcome initiatives, referred to as core measures, that continue to drive quality outcomes seventeen years later. CMS's other initiatives, such as Hospital-Acquired Conditions reduction program, Hospital-Readmissions, and Value-Based Purchasing have also served as drivers of organizational change in support of quality, safe care. Leaders of healthcare organizations have had to re-envision what organizational success looks like in an environment of continual change and adaptation. Initiatives that had previously been dictated by the executive for implementation by subordinates have had to be transformed to ensure rapid integration into clinical application in order to keep up with increasing demands of regulators, payors, and patients (American Hospital Association and American Medical Association, 2015; Wessel, 2012).

Healthcare administrators have increasingly turned to point-of-care clinicians, individuals and interprofessional teams alike, to better understand drivers of change, a relational approach to organizational leadership that moves beyond the top-down driven decision making commonly used in traditional hierarchical organizations (Clarke, 2018; Conrad & Poole, 2012; Eisenbeiss, van Knippenberg, & Boerner, 2008). The role of the Registered Nurse (nurse) to patient outcomes has been well documented (Aiken, 2014; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Dunton, Gajewski, Klaus, & Pierson, 2007). The Institute of Medicine's (2011) Future of Nursing report defined the critical role the nurse plays in desired organizational change, and

French-Bravo and Crow (2015) documented the role of nurse buy-in to the success of organizational initiatives.

What is not well studied is how nursing discourse influences nurse buy-in to organizational initiatives so that healthcare organizations realize desired, sustainable change in this turbid healthcare environment of ever-changing expectations. Giddens's (1984) structuration theory may be a key management practice consideration to tying together the role of discourse to nurse buy-in. To make that connection, however, requires a review of both buy-in and discourse as building blocks of organizational change.

Buy-in

Organizational outcomes are directly related to the efforts of individuals within the organization who conduct the prerequisite work. When those individuals feel valued by the organization, when they are empowered and supported in the work they do, they have the capacity to effect desired organizational outcomes (Faulkner & Laschinger, 2008; Liao, Toya, Lepak, & Hong, 2009). That capacity to act is an outcome of buy-in. French-Bravo and Crow (2015) defined buy-in as "the act of an individual or group giving something in return for something else" ("What Buy-In Means," para. 1). The authors identified several factors that influence buy-in. First, they argued that buy-in requires the presence of three psychological states: meaningfulness, safety, and availability (Kahn, 1990). Meaningfulness infers a return on investment. From the perspective of the nurse, buying-in-to an organizational initiative would infer a giving of one's self via time, energy, or other personal resource with an expectation that the effort of giving of one's self would result in an outcome desired by the individual.

Psychological safety is the capacity to present one's self fully without fear of consequences. Psychological availability is the identification of resources (physical, emotional,

and psychological) to participate. Other factors influencing buy-in include initial engagement, trust, balance of options, personal connection and consequences, and time.

Desired organizational outcomes, while influenced at the micro level by individuals, are usefully understood at the macro level of collective group processes. Barker (1993) offered an excellent example of how normative rules were formed through an evolution of group values and concertive control, or "consensus about values, high-level coordination, and a degree of self-management by members or workers in an organization" (p. 408). In his study of a small manufacturing company that transitioned to a self-managing team model of control, Barker argued that team-centric concertive group control served to strengthen rather than loosen the "iron cage of rule-based, rational control" (p. 408) traditionally observed in a bureaucratic, hierarchical organizational structure, and consequently influenced organizational outcomes. Unlike a traditional hierarchy and key to understanding the power of buy-in, is the fact that participants in Barker's study were *more* aligned with the organization's goals when they were self-directed. Barker's observation of consensus among members of a team is a consequence of discourse and an antecedent to buy-in.

Consensus is also a recursive action in that the act of coming to consensus spurs dialogue that continually influences the degree of consensus among members of the team. Team members individually and then collectively create the meaning that drives their work and that collective meaning then drives normative rules related to the work. Team members buy-in to shared values of the group and then contribute to promoting those values, are driven to perform, and are collectively accountable to each other for outcomes.

An example of individual and collective nurse buy-in can be found in the workings of a unit-based nursing practice council. A unit-based practice council is one component of a model

of shared governance through which decisions related to professional nursing practice are made by those nurses who must perform the work (Porter-O'Grady, 1992). In this model of shared governance, nurses influence their own professional practice (Hess, 2004). Shared governance models shift our attention away from the metaphor of organizations as machines as outlined by Morgan (2002) in which participants have little control over their work and are expected to continually repeat the same processes in anticipation of the same result. Rather, shared governance models are more closely aligned to Morgan's metaphor of organizations as brains in which emergent organization through collective collaboration arises. See also the later discussion of organizations as talk as described by Suchman (2011).

Participation in a unit-based practice council requires buy-in – a trading of the nurse's time, expertise, and energy for what she anticipates will result in better bedside nursing practice as a result of her participation. The antecedents of buy-in as offered by French-Bravo and Crow (2015) guide an individual nurse's buy-in to the work of a unit-based practice council. As groups of nurses collaborate on initiatives, their conversations evolve to create a collective understanding of how they should adapt their nursing practice in support of the success of the initiative. That collective understanding drives normative rules through which nurses hold each other accountable to ensure the success of the initiative.

Discourse as a Formative, Complex Process

Discourse is deeply interwoven into the practice of buy-in. Porter-O'Grady and Malloch's (2011) discussion of the leader's role in carefully aligning those who have the power and influence with the decision-making opportunities that most align with that particular power and influence is not unlike the role of discourse to nurse buy-in. Porter-O'Grady and Malloch argued that those who have the power to effect change should be in a position to make decisions

as to how that change is designed and implemented. Translated to nursing, if an initiative is proposed that requires nurses to act or respond differently, such as changing practice to reduce patient falls, nurses should participate in the design and implementation of that change since they are the individuals who have to do the work. Involving the nurse in those key programmatic decisions facilitates buy-in and results in discourse among nurses that further strengthens the program via nurse ownership of outcomes.

Likewise, failure to involve the nurse in those programmatic decisions may result in a lack of nurse-buy in, and subsequent discourse surrounding the initiative may impede the program should nurses collectively believe the program is not beneficial. Discourse among nurses at the point of care is leadership insomuch as discourse results in "building partnerships, interfaces, relationships, and points of convergence in the network that, when aggregated, move the system effectively in a direction that ensures its long-term viability" (Porter-O'Grady & Malloch, 2011, p. 115). The relational aspects of buy-in are formed and reformed through discourse.

Organizational conversation is an action, yet it can also be the spark that precedes action and inaction within organizations as well (Suchman, 2011). Suchman used the metaphor of organizations as talk. As people within organizations converse, their understanding of and relation to whatever topic under discussion evolves. For example, two nurses are discussing a policy on hand hygiene. One nurse expresses to the other how challenging it is for her to use the hand sanitizer outside of the patient's room while her hands are full of supplies she needs to take into the room. The nurse listening to his coworker's challenges responds by offering the various ways in which he works through similar challenges while still following the hand hygiene protocol. Both nurses' understanding of the hand hygiene policy has changed based on the

conversation. The first nurse now has ideas as to how she can work through the challenges she's experienced, while the second nurse now knows his coworker has struggled with a policy he has had no challenges with and he is determined to keep an eye out for other coworkers who may need guidance.

Suchman (2011) suggested that for large-scale organizational initiatives, or any initiative for that matter, attention should be paid to the every day interactions among individuals within the organization rather than to the interactions leaders desire of those individuals. When leaders pay attention to how workers pattern meaning, and engage those workers in discussions and activities intended to spur thoughtful discussion of desired change, those patterns of meaning begin to shift and organize to a desired outcome. Equally possible is a shifting of meaning that results in either an undesired or unconsidered outcome. An effective leader is just as open to his or her shifting self-awareness in the act of conversing as he or she is to accepting that the act of conversation may result in unintended outcomes.

Mumby (1987) articulated the role of narratives in shaping and legitimizing organizational reality. Processes within organizations are shaped by narratives told by members and become dominant processes as they are legitimized through ongoing narrative construction. Power as represented by those in positions of authority influences dominant organizational narratives; as such, those with authority are more likely to get others to buy-in to and promulgate any given narrative. Dominant narratives in turn serve as the foundation for organizational structure in the form of normative behaviors that are reinforced by those with power. Mumby referenced Giddens's (1984) writing on organizational structuration, particularly the duality of structure, in reference to power and noted that "in this context, power becomes double-edged in the sense that it serves not only as a means for domination, but also as the vehicle through which

social actors can potentially liberate themselves from domination" (p. 117). An individual within an organization may understand his or her role within that organization through interpretation, creation, and recreation of narrative, which in turn shapes the normative structure of the organization.

Ford and Ford (1995) articulated a framework for intentional change through communication. Building on the work of Giddens (1984) and others, Ford and Ford argued that change only occurs within human social interactions that are created and recreated through discourse. In this line of thought, communication drives change rather than change driving communication. Suchman (2011) argued that the metaphor of organization as machine, inclusive of a command and control, manager-centric approach to operations, is fundamentally problematic because human beings by nature are not machine-like in function nor are they free from variance. The model of organization as machine is unable to account for nuances of human nature, behavior, and self-will that influence both the work force and the work product. In contrast, a model of organization as conversation does not divest humans from the equation of workplace productivity and effectiveness. In fact, Suchman argued that this perspective,

> Shows us an organization not as a reified object, separate from us, that we can manipulate and control, but as a set of ongoing interactions – a conversation – of which we are an inseparable part. Not just a metaphor, this is literally true. (p. S44)

While discourse can both build and tear down, its capacity to do so is not linear. The same conversation occurring multiple times between two individuals can be perceived by either of the individuals differently based on a variety of influencing factors. Discourse is a complex system of interactions resulting in emergent, self-organizing behavior within healthcare. The interactions of a group of nurses at one level of the health care system can influence outcomes at

a different level of the system (Sturmberg & Lanham, 2014). As described by Morgan (2002), complex nonlinear systems, such as healthcare organizations, include transactions that are both ordered and chaotic.

Yet through the chaos emerges order. For example, an ICU nurse's interpretation of a hospital's visitation policy can have an unanticipated influence on both the patient and family members should the patient be transferred to a different ICU. Nurses working in the ICU to which the patient is transferred may interpret the same visitation policy in a more restrictive manner than nurses in the first ICU. In the more restrictive environment, patients may feel more isolated, resulting in emotional distress, and family members may feel that their participation is not valued. The discordant approaches to visitation can create chaos and uncertainty initially, particularly if nurses and administrators fail to recognize that a small change in one component of the system can result in much greater change to the system as a whole (Davidson, Ray, & Turkel, 2011; Patton, 2011).

In systems with strong shared governance models, nurses take their experiences regarding visitation back to their individual unit-based practice councils. Those unit-based practice councils then take suggestions for change to a broader council that includes representatives from all unit-based ICU practice councils. Thus, a new order begins to arise as nurses learn about unit-specific visitation policies by occasionally being asked to work in different ICUs and experience both patient and family member reactions. Nurses incorporate what they have learned into their home ICU practices. Through careful collaboration and negotiation, a standardized visitation policy for ICU visitors emerges.

Leaders who are committed to achieving desired outcomes benefit from knowing how both buy-in and discourse drive change. Buy-in is not a mandated attribute; rather, buy-in is a

result of an environment in which individuals willingly give of themselves to the betterment of the whole. Buy-in is a consequence of discourse among individuals. How individuals talk about change directly influences whether change occurs or not. Giddens's (1984) structuration theory serves as an excellent framework through which organizational change occurs through discourse.

Theoretical Analysis

Attention to the principle components of Giddens's (1984) structuration theory, including both structures and processes through which discourse shapes reality, offers managers a novel approach to supporting organizational change. Giddens, a British sociologist, defined structuration as the building of "social relations across time and space, in virtue of the duality of structure" (discussed later; p. 376). Agents or actors, used interchangeably by Giddens, are individuals within organizations. As nurses are the subjects of consideration in this manuscript, the terms nurse or nurses will be used in place of agent or agents, respectively.

Agency refers to the capacity of nurses to act. Agency also includes actions, both intentional and unintentional, taken by nurses. Structure is both rule and resource and structures are rule-resource sets. An organization's policies can be likened to structures, inclusive of rules that dictate how the work is to be done and resources that guide actions in support the work. Yet Giddens's structures are less tangible, occurring as memory traces. Through conscious and unconscious monitoring of actions, nurses use these memory traces to shape social systems. Simply articulated by Kirby and Krone (2002), structures are combinations of rules and resources from organizational discourse that create "'recipes' for acting" (p. 55). From the perspective of structuration, a healthcare organization's policies *are* what nurses talk about and are *continually shaped* by what nurses talk about.

The reflexive nature of humans is foundational to structuration theory. Acts of nurses are not guided by a sequence of pre-calculated intentions; rather, acts result from a continuous system of reflexive awareness. Nurses know what they are doing and why they are doing it while they act, which is a manifestation of practical consciousness. Social acts are recursive. Nurses do not produce social activities; rather, social activities are created and recreated by nurses as nurses express themselves through interactions with others (Giddens, 1984).

This recursivity is evident in the team approach to emergency resuscitation in the intensive care unit (ICU). Actions occur in an emergency as team members communicate with each other, and additional dialogue results from those actions that guide further actions or inactions. It is through these discursive expressions that conditions exist to promulgate or repress social activities.

The duality of structure is key. Nurses and structures are not independent phenomena; rather, they represent a duality. Social acts create the rules and resources, or the structure, in which nurses work, yet each social act continually recreates those same rules and resources. In that regard, structuration is both a noun in the form of rules and resources and a verb in the form of continually recreating those rules and resources. Rules and resources are the social system and continually recreate the social system in which nurses interact. Structuration, therefore, is an action that promotes or transforms structures and thus produces and reproduces social systems.

Structuration exceeds the walls of organizations to become an individual's worldview. A social norm is a structure, a rule-resource set as described by Giddens (1984). We learn any number of social norms from an early age that structure the world in which we live. By enacting those norms we reinforce their structure, and by talking about those norms we reshape their structure. The use of cell phones in social settings is an excellent example of a normative

behavior influenced by how groups of individuals both talk about as well as enact the social norm.

For example, a group of adults gather regularly for dinner and conversation. The group set a rule that during dinner all cell phones are to be on vibrate and not answered so as to focus attention on the conversation at hand. As new friends are added to the group, other friends ensure they are aware of the no-cell phone rule. Inevitably, new members share their own experiences with phone interruptions during inopportune times and embrace the rule. While a simple example, the sharing of stories reinforces the normative behavior.

Practice Implications

Giddens's (1984) structuration theory serves as an excellent foundation for nurse buy-in to organizational initiatives. Nurses play the role of agent, having the capacity to influence change by buying in to organizational initiatives or not. Agency is the capacity of the nurse to act, as well as the intentional and unintentional actions taken by the nurse. Rules and resources include the policies and procedures, spoken and unspoken; organizational history and culture; work environment; and societal contexts that form structures to which nurses act and react. These structures exist as memory knowledge that continually influences thought and action. For example, historical context, or the way things used to be, is oftentimes considered by the nurse during current organizational change, particularly if the historical state is perceived as better than current or proposed future state.

Nurse buy-in to organizational initiatives is not independent of the discursive process of structuration. Nurses talk. They talk to colleagues they work with directly, with colleagues who work elsewhere in the hospitals, with acquaintances who work in other hospitals, with supervisors and managers, with friends, and with family. As initiatives are proposed, and in the

constantly shifting healthcare environment there are always new initiatives, nurses consider the current state of the environment. They consider if the envisioned environment post-initiative implementation will be better or worse than the current state. How they picture that new environment will influence their willingness to buy-in to an initiative. Some nurses may have worked in hospitals where the proposed initiative was implemented. They may have experienced a successful initiative or a failed initiative, and nurses will share those experiences with each other. The mere conversation surrounding the initiative may result in micro actions, or those very subtle activities done without conscious effort, in support of or in opposition to the initiative.

Rules and resources that form the foundation for action are also inclusive of the factors that enhance buy-in as described by French-Bravo and Crow (2015), including psychological meaningfulness, safety, and availability; initial engagement; trust; balance of options; personal connection and consequences; and time. Nurses' experiences with any and all of these factors shape their predilection for buying in to an initiative. For example, if nurses recall situations of misplaced trust, their capacity to trust will be influenced by those memories.

A hypothetical scenario is provided to delineate how Giddens's (1984) components of structuration are interwoven in nurse buy-in to an organizational initiative. In this scenario, agents are primarily nurses, but are also patients. Agency refers to the actions nurses take in response to rules and expectations outlined by management. Likewise, agency also refers to the actions management takes in response to nurses' responses to those rules and expectations. Structures are hospital policies and procedures, spoken and unspoken; recollections; and relationships that influence decision-making among nurses in the scenario.

Embedded in a small community hospital is a geriatric psychiatric unit that accommodates up to 30 adults over the age of 55 who have acute psychiatric conditions that require hospitalization for intensive management. Most patients are at a heightened risk for unexpectedly falling because of the impulsive nature of their acute psychiatric episode, as well as their comorbid conditions. Patients are generally in bed by 9:00 P.M. and nurses pass medications, perform any last minute assessments, and assist patients to the bathroom during the hour before bedtime. Both age and impulsivity increase the risk of falls in this patient population, and each patient sleeps in a bed equipped with an alarm that activates if the bed detects a significant shift in weight, like a patient attempting to exit the bed. When activated, the alarm sounds at the nurses' station and a light activates outside the patient's room to guide responders to the appropriate location.

History adds a significant contribution to this story. The complexity of the patient population has increased over the past five years, partly due to the general aging of those in the surrounding communities but primarily due to the closing of a sister geriatric psychiatric unit in a larger neighboring city. Nurses and physicians alike speak to the increasing severity of outbursts and impulsive behaviors of the patients in the unit. Two years ago, the hospital housing the geriatric psychiatric unit went through what administrators referred to as a "right sizing" of the workforce and nurses referred to as "mass layoffs." Administrators argued that the hospital's financial state could no longer support the nurse staffing ratios that had been in place for as long as most nurses could recall. Nurses transitioned from caring for 4 to 5 patients each to 6 to 8 patients each over the course of several months.

One hypothetical consequence of an environment with more patients who are impulsive and fewer nurses was an increase in the rate of patient falls in the geriatric psychiatric unit. The

unit average of 1 to 2 falls every quarter slowly increased to 1 to 2 falls every month, most commonly occurring several hours after patients were placed in their beds for the night. Consequently, hospital administrators tasked the unit NM with reducing the number of patient falls. The NM reacted quickly, implementing three specific activities to reduce patient falls: requiring nurses working the day shift to spend more time assisting patients to be more physically active during the day, requiring nurses working the night shift to assist each patient to the toilet every night immediately before bed to reduce the likelihood of the patient getting up unassisted to use the toiled at night, and requiring a quicker response by all nurses when a bed alarm sounded.

The NM's directive was the topic of conversation at the nurses' station and among smaller groups of nurses. Nurses working the day shift commonly agreed that the fall concern was not their problem to deal with. After all, most of the falls were on night shift and nurses working the day shift believed they worked harder and had less time to spare than nurses on the night shift anyway. Several nurses recalled an initiative several years prior during which nurses working the day shift were required to conduct more activities with patients throughout the day because of a similar concern with patients falls at night. As one day shift nurse was overheard saying to a group of coworkers, "It didn't work then, why would it work now?"

There was also an underlying current among nurses of distrust in hospital administrators, including the NM. Nurses working the day shift had more seniority than nurses working night shift, and many could recall what one nurse referred to as "the good old days" when there were plenty of nurses to care for the patients. A nurse new to the department told his peers that at the hospital he had recently left, the most significant reduction in patient falls occurred when physicians began ordering diuretics be given in the morning instead of the evening. The small

group conversations resulted in a collective decision, albeit unspoken, that day shift nurses would continue their work without paying particular attention to the NM's directives. Their discourse and distrust in administrators resulted in a lack of buy-in to the fall reduction initiative.

Nurses on the night shift also talked among each other. Several nurses shared stories of day shift nurses complaining they had been too busy during the day to take their patients for a walk as directed by the physician. One tenured nurse told the story of how she was involved when the unit was originally constructed. She said that she had told administrators at the time that placing the nurses' station at one end of the unit was not good because nurses would be too far away from patients on the other end of the unit should nurses need to respond quickly. Several nurses discussed that the NM was just "reaching for straws" and a reiteration of the current fall policy was not going to do anything to reduce patient falls. Similar to the collective decision of nurses working the day shift, nurses working at a night also decided that they would continue their current practices. Both groups of day shift and night shift nurses took a "wait and see" approach before exerting additional efforts to comply with the NM's directives.

Discourse among nurses shaped their practice. In this example, both discourse and historical context resulted in nurses not buying in to the manager's directive to reduce patient falls. Consequently, nurses did not implement the fall reduction initiatives into their practice. The rules and resources of the organization were the system in which nurses chose to practice and continually re-created the system in which they chose to practice, as described by Giddens (1984).

Conclusion

Change is constant in healthcare. An organization's ability to focus on factors that influence buy-in as described by French-Bravo and Crow (2015) may influence discourse in such

a way as to ensure buy-in to organizational initiatives. Likewise, when organizational leaders fail to focus on factors that influence buy-in, resulting discourse can also influence buy-in in an undesirable way. Leaders of healthcare organizations would benefit from understanding how nurses communicate about policies, procedures, and planned change.

How nurses talk about the work they do *is* the social system in which they work and *creates* that same social system. Components of Giddens's (1984) Structuration Theory are exemplified in nursing practice in the form of policies and procedures, as written and as interpreted, which can be polar opposite in meaning and intent; historical recollections that influence present action; and continual discourse that can both subtly or dramatically alter the social system.

How nurses communicate with each other and are communicated with by the organization influences their willingness to buy-in to initiatives. Dialogue between groups of nurses and between nurses and management continually shapes and reshapes the initiative. That dialogue and subsequent implementation of the continually evolving initiative shapes the social system in which nurses work. Likewise, the dialogue and subsequent decision to not implement the initiative also shapes the social system.

Through active listening and engagement, leaders may have a better understanding of how organizational rules and resources are actualized among those who perform the work of the organization. In the process of listening, leaders may realize that how nurses go about their work is very different than how leaders would expect nurses to go about their work based on established policies and procedures. When leaders are attuned to the real social system that guides practice, not the social system they assume exists, organizations will be in a better position to achieve desired organizational change.

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CHAPTER 3

The Importance of Nurse Manager Communication in Understanding Nurse Buy-In to Initiatives that Enhance Patients' Experiences with Care

Abstract

Aim

To understand how NMs' communication with nurses relates to nurses' decisions to buy-in to organizational initiatives to enhance PEC.

Background

The role of the nurse to patient experience is well established, yet little is known about how the communicative relationship between manager and nurse relates to nurse buy-in to initiatives that support PEC.

Method

An exploratory qualitative descriptive study was conducted with 15 nurses from two inpatient medical-surgical units in a large acute care hospital using semi-structured interviews.

Results

Three themes were identified. The communicative relationship was developed and strengthened through the manager's: (a) use of multiple methods to communicate and influence change, (b) engaging and supporting staff, and (c) promoting staff-led decision making.

Conclusions

Nurses who describe a strong communicative relationship with their manager are more willing to be engaged and to buy-in to initiatives.

Implications for Nursing Management

An assessment of the communication between the frontline NM and his or her team is important for understanding why initiatives to support PEC are or are not yielding desired results.

Keywords

communication; communicative relationship; patients' experiences with care; buy-in

Background

The pace of change in healthcare is arguably at a level higher than many clinicians and administrators have experienced in their professional careers. The continually evolving expectations of patients, payors, and regulators require those who provide care and those who support the provision of care be both nimble and intentional in their practice. Since its publication in 2008, the Institute for Healthcare Improvement's Triple Aim framework has been a guide for the United State's healthcare system as it navigates the waters of change (Berwick, Nolan, & Whittington, 2008). As the largest group of healthcare clinicians in the United States, nurses have been and will continue to be responsible for initiating change and sustaining initiatives to promote quality of care (Institute of Medicine, 2011).

One evolution in healthcare is the inclusion of patients' experiences with the care they receive as a component of the healthcare encounter. The role of the Registered Nurse (nurse) in leading patient experience has been well established (Aiken, 2014; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Dunton, Gajewski, Klaus, & Pierson, 2007). The role of the NM in leading a healthy environment in which nurses can perform their work is also well known (Cziraki & Laschinger, 2015; Faulkner & Laschinger, 2008; Manning, 2016; Smith Lewis & Cunningham, 2016). What is not well known is how communication between the nurse and the NM influences PEC. To understand that relationship, however, requires an understanding of the vital role of communication within organizations.

An organization evolves through conversations among its members (Ruddy, Thomas-Hemak, & Meade, 2016). In other words, the organization is not comprised of its members; rather, the organization is a byproduct of the actions of and interactions between its members. Ruddy et al. argued that cultural transformation can only occur when leaders facilitate a shift

toward a shared worldview, one in which each member's purpose aligns with the purpose of the organization. Conversations among members serve to strengthen a shared worldview in support of organizational outcomes.

Few would argue that communication is central in healthcare, whether between NMs and nurses, physicians and nurses, or clinicians and patients, yet much remains to be known about those communicative relationships, particularly between NM and nurse. An understanding of how the NM's communicative relationship with a nurse relates to that nurse's buy-in to initiatives that enhance PEC would help to fill in a gap in the literature. Buy-in is defined as "the act of an individual or group giving something in return for something else" (French-Bravo & Crow, 2015, "What Buy-In Means," para. 1). In this study, 'giving something' is understood as acts or behaviors such as nurses' time, willingness to support and participate, offering expertise, etc., and 'in return for something' is understood as extrinsic factors such as experience that supports career growth, as well as intrinsic factors such as the desire to support the common good for patients.

Aim

The purpose of this study was to understand how NMs' communication with nurses related to nurses' decisions to buy-in to organizational initiatives to enhance PEC. The research questions included:

- What initiatives do nurses identify as activities they undertake to enhance PEC?
- How do nurses describe their NM's communication, including how that communication made the nurse feel and how participation in initiatives changed based on that communication?

- How do nurses describe conversations the nurse had with peers about NM communication and how participation in initiatives changes based on communication with peers?

Methods

Philosophical Framework

This study was conducted through the framework of naturalistic inquiry and supported by a position of ontological realism and epistemological constructionism. A key assumption in this study was that social phenomena are equally explained by what we experience and how we experience it. Through the lens of constructionism and assessed using a qualitative descriptive approach, an individual's reality results from the relationships the individual has with others (Gergen, 1985; Sandelowski, 2000).

Study Design, Setting, and Sample

This study used a qualitative descriptive design with purposive sampling of nurses recruited from two inpatient medical-surgical units in a large acute care, Magnet designated hospital in a Midwestern U.S. urban metropolitan area. The hospital's staffed bed count is greater than 800, and the combined bed count for the two units is 50. The units have an average combined daily census of 47. The units were led by separate NMs. The hospital had achieved a four-star summary rating (the highest rated hospital in the area) for PEC as identified by CMS's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for reporting period April 1, 2016 through March 31, 2017 (CMS, 2017). A hospital with a high rating for PEC was selected to determine if the communicative relationship influenced nurse buy-in to relevant initiatives. Inclusion criteria included a minimum of three months worked on the unit, no less than 20 worked hours per week on average, and 50% of worked time spent

providing direct patient care. Nurses were excluded if the majority of their worked time was spent in a charge nurse or other supervisory role.

Data Collection

Semi-structured interviews using open-ended questions (Table 3.1) were conducted in September 2018. The principal investigator (PI) conducted in-person (n = 11) and telephone (n = 4) interviews and took field notes to supplement participants' audio-recorded responses. Interviews averaged 45 minutes to an hour in duration. Interviews continued until saturation was reached with no new information presented by participants. Participants completed a brief demographic questionnaire that included age range, ethnicity, and gender.

The PI also observed two staff meetings, one from each unit in which participants were sampled. Each staff meeting was conducted by the unit's NM and included a review of the previous fiscal year's performance and goal setting for the current fiscal year. Notes were taken during the observations. Artifacts (e.g., emails, PowerPoint presentation of staff meeting) were also collected to supplement participant interviews and staff meeting observations.

Ethical Considerations

Study approval was granted by the Human Subjects Committee (HSC), the designated Institutional Review Board for a Midwestern academic medical center, under protocol STUDY00142779. Confidentiality was maintained using PI-assigned pseudonyms and data were aggregated to the combined unit level.

Data Analysis

Recorded interviews were transcribed verbatim. Each transcribed recording was then carefully compared to the audio recording to ensure accurate transcription. Elo and Kyngas's

(2008) conventional inductive content analysis approach was used for data analysis. Each transcript was analyzed for meaning units, condensed meaning units, and codes.

Table 3.1

Interview Questions

- Tell me about hospital or unit initiatives to enhance patients' experiences with care, also known as patient satisfaction? (Probe: Some examples could include hourly rounding, nurse bedside shift report, or multidisciplinary rounding. Does your unit participate in these types of initiatives or others that are similar?)
- Tell me about a time when your manager communicated with you about one of those initiatives. (Probe: Are there other examples that come to mind?)
- How did your nurse manager communicate that message?
- What other messages have you heard from your nurse manager about initiatives to enhance patients' experiences with care?
- Tell me about what you thought or felt as you received that communication from your nurse manager.
- Tell me about conversations you have with your peers specific to communication you receive from your nurse manager.
- In what way(s), if any, did your participation in initiatives to enhance patients' experiences with care change because of communication you received from your nurse manager?
- In what way(s), if any, did your participation in initiatives to enhance patients' experiences change because of conversations you had with your peers?
- How important is your manager's communication to your daily work?
- Describe a situation during which your manager's communication with you motivated you to change your attitude or behavior about an initiative.
- Describe a situation during which your manager's communication with you did not motivate you to change your attitude or behavior about an initiative.
- Is there anything you would like to share that we have not already discussed?

Codes were arranged into categories and categories into themes. The PI conducted all aspects of data analysis and peer debriefing among researchers was used to scrutinize findings and explore alternate interpretations.

Methodological Rigor

Lincoln and Guba's (1985) criteria (i.e., credibility, dependability, confirmability, and transferability) were used to support methodological rigor and trustworthiness of study findings. Multiple sources (e.g., observations, interviews, and artifacts) were used to triangulate the data in

support of both credibility and confirmability. Credibility was also supported with each nurse being provided a verbal synopsis of the conversation before the end of each interview and asked to provide changes or additions. Notes were taken during all phases of the research to provide a careful audit trail in support of dependability. Transferability of findings was supported through a rich description of results.

Results

Fifteen nurses participated in the study. All participants were white. The sample was predominantly female (86.67%) with the remaining participants identifying as male. The majority of participants were 25 to 34 years of age (66.67%), and the remaining were 18 to 24 years (13.33%), 35 to 44 years (13.33%), and 45 to 54 years (6.67%). The majority of participants worked day shift (86.67%).

Participants identified at least one initiative in which they participated to enhance PEC. Responses to this first interview question were important so as to not bias participants with PI-initiated examples as to what may constitute initiatives that enhance PEC. This first question provided the foundation on which participants could articulate how their NM's communication influenced their participation in initiatives they identified as important. The primary initiative identified was hourly rounding on patients, a patient-centered approach involving staff members checking on patients hourly to ensure their needs are met. Daily patient hygiene, satisfaction with meals, staff-signed cards of encouragement mailed to patients after discharge, promptly responding to call lights, room cleanliness, and patient quality and safety goals were other initiatives identified by participants that supported PEC.

Additionally, participants in both units described the presence of Lean implementation in their units, a quality improvement methodology that focuses on waste reduction in order to add

value to customers or patients (Moraros, Lemstra, & Nwankwo, 2016). One participant described Lean implementation as a focus on eliminating waste and ensuring efficient patient-centered care and all initiatives described by participants were undertaken from a Lean implementation approach.

Three themes were identified specific to understanding how NMs' communication with nurses related to nurses' decisions to buy-in to organizational initiatives to enhance PEC (Table 3.2). Each theme consisted of key categories that further described and reinforced participants' experiences. The themes and categories were consistent across participants and units, with the exception of one unit-specific category (NM as a filter to the system) described in the second theme.

Table 3.2

Themes and Categories

Themes	Categories
Multimodal Approach to Communicating and Influencing	• The act of communicating • Data communicate results and influence performance • NM as role model to influence change • NM influences unit culture • NM has characteristics desired by staff
Facilitating Change through Staff Engagement and Management Support	• NM as a filter to the system (unit specific) • NM supports and enables individuals and the collective team • Shared accountability for successes and failures • NM seeks to understand and helps others to understand
A Nurse Manager-Facilitated Approach to Staff Led Decision-Making	• Staff understand unit goals • Staff drive the work of the unit with NM support • Peer interactions support unit work

Multimodal Approach to Communicating and Influencing

Participants described multiple ways in which their NM communicated and influenced change. Each described multiple methods of disseminating information and articulated the NM's influence on the unit's culture.

The act of communicating. Participants reported multiple modes through which the NM communicated information, including email, Managing of Daily Improvement (MDI) boards that displayed progress in various unit initiatives, huddles, phone calls, text messaging, staff meetings, yearly evaluations, and regularly scheduled one-on-one meetings. Participants who primarily worked night or weekend shifts reported email and text messaging to be the primary modes of communication from their NM, while participants who worked day shifts reported face-to-face interactions as the primary mode of communication. Participants who worked night or weekend shifts reported a personal connection with their NM, developed during orientation and staff meetings, that added value to email communication, yet email communication was not perceived to be as personable as face-to-face interactions. According to one participant,

> Speaking in person is much different than email. . . . During orientation, all that process, I was here during the week. So that was our time to really get to know each other personally. So I feel like having that time was really important because you lack a little bit of connection because it is email.

Unit charge nurses were also identified as a mode of communication wherein communication from the NM was delivered to participants via charge nurses. Participants described how charge nurses were perceived to be extensions of the NM when charge nurses were communicating change. Charge nurses also played a role in influencing change as

described later. Participants valued the multiple modes of communication and believed they always had access to information pertinent to the work of the unit.

Data communicate results and influence performance. The NM made data available to participants so they were aware of how their performance influenced PEC. Participants perceived data to support the rationale for change and data were integral to communication. The NM provided HCAHPS results during staff meetings and results were displayed on MDI boards. Comments provided by patients from the survey were also communicated to staff, and participants noted positive comments were encouraging and spurred engagement in those initiatives that supported PEC. Data regarding other quality measures were also regularly presented. Participants reported facts were important to the NM and were used to make decisions. One participant described the NM as "very strong in [including] data and showing the statistics and the facts behind why we're doing certain things." Participants, consequently, valued data as a mechanism to understand progress and to support their continued engagement in the change process.

The nurse manager as role model to influence change. The NM was viewed as a role model who positively influenced change. Participants perceived change as an innate component of their work and recognized desired performance could only be achieved if they were willing to change practice. Their willingness to change was influenced by the NM valuing and supporting the individual. One participant described how the NM used the concept of a tree's roots to symbolize the relationship between nurturing of staff and unit initiatives,

> In order for a tree to be plentiful and healthy, you have to water the roots. She [the NM] was explaining to us that we're the roots. If we're satisfied and taken care of and we can

> build relationships in the professional setting, then that's going to continue to impact the care that we give to our patients.

The NM was not always present yet positively influenced change in her absence via the charge nurses who were assigned during every shift. All participants, but in particular participants who worked night and weekend shifts, spoke to charge nurses as extensions of the NM. Charge nurses were described as reflecting both the direction and the thoughts of the NM, providing constructive feedback, and relaying communication from NM to nurse and vice versa. The NM's influence was so embedded in the role of the charge nurse that one participant who primarily worked night shifts asked if she could respond to some of the PI's questions about the NM by answering from her perspective of interacting with charge nurses. The participant viewed the NM and charge nurses as one in the same because the NM's leadership was so deeply embedded in the charge nurse role. As articulated by another participant,

> [The NM] has set up the leadership team [so] that I can also go to [the charge nurse] and say, 'hey, I'm really worried about this. I don't know how we're going to get this patient out of here'. . . So that [charge nurse] is the extension of [the NM] in that.

Similar to the esteem one holds for personal or professional role models, participants described not wanting to disappoint their NM, so not buying-in to an initiative brought forward by the NM was not a consideration. Described as "the mom of the unit," all participants described the respect the NM received and none could identify a time when the NM was spoken about negatively, even during private peer conversations. After all, "she's held me to that certain expectation and I don't want to break that trust, because I feel like [she] has a great sense of trust in all of us."

Nurse manager influences unit culture. The NM was instrumental in creating and sustaining an innovative, flexible, patient-centered culture wherein participants felt safe to ask questions and both staff and management were equally accountable for successes and failures. One participant reported doing what was best for the patient was the guiding principle for all work undertaken in the unit, and doing what was best for the patient required good communication. When asked what percentage of time the NM supported an open environment in which people were comfortable communicating, a participant responded "one hundred percent. . . . She always wants you to tell her what's going on and what's bothering you. . . . She'll find a way to make a solution with you. I feel like that's key. Communication is key."

The NM supported a culture of teamwork by hiring the right people. Participants experienced pride in their unit and they attributed unit success in part to their NM. They desired team members who shared their passion for patient care and teamwork. Participants believed the NM's passion for the unit attracted others to work in the unit and that passion served as an anchor to keep staff engaged.

Nurse manager has characteristics desired by staff. Participants spoke highly of their NM and used multiple adjectives and phrases when speaking about her. Table 3.3 includes the various descriptors participants used when speaking of their NM. A participant articulated sentiments shared in part by all participants when she responded to how her participation in initiatives changed because of how her NM communicated with her,

> I really respect [the NM]. . . . She's nice. . . . [and] she's a very intentional person. In turn, that makes all of us feel well heard on this unit, taken care of. In turn from that, we want to participate in the things that keep our unit living up to the standards and reputation that it has.

Table 3.3

Participants' Descriptions of Nurse Manager

Amazing	Approachable	Attentive	Aware	Balances personal and professional life
Believes in team	Caring	Communicates well	Communicates positively	Compassionate
Compliments	Constructive	Deliberate	Direct	Does not micromanage
Easy to communicate with	Empowering	Encouraging	Energetic	Expresses thanks
Exudes excellences	Fluid relationship	Follows-up	Friend	Genuine
Great communicator	Great leader	Honest	Humble	Inspires
Intentional	Motivating	Not confrontational	Not punitive	Offers to help
Open	Open door policy	Peer	Personable	Positive
Puts a positive spin on communication	Present	Professional	Reasonable	Relatable
Relaxed	Relaxed when conversing	Role Model	Smart	Straightforward
Strong communication skills	Strong leadership skills	Sympathetic	Transformational	Transparent
Trusts staff	Trustworthy	Upbeat	Welcoming	Wonderful

Facilitating Change through Staff Engagement and Management Support

While there were multiple modes through which the NM communicated and influenced change, change associated with initiatives was facilitated by and supported through the NM's engagement with staff.

Nurse manager as a filter to the system. Participants in one of the units reported that some initiatives (e.g., hourly rounding) were directives from the system, someone higher than their NM. This may, in part, be related to a lesser degree of Lean methodology integration into the unit when compared to the other second unit, which was identified by participants as the Lean model for the organization. One participant lamented her frustration with and servitude to the system yet acknowledged she could not identify to whom she was referring when speaking of the system. The system, however, was deemed by participants to be at a level higher than their NM.

The NM served as a filter between the system and participants, effectively translating messaging from the system so that it was, at the least, neutrally received by participants rather than being perceived as an unwelcome directive. Participants did not hold the NM responsible for decisions mandated by the system. When articulating the NM's role as a filter to the system, a participant stated, "I think she really has our back, no matter what." Another participant reported when staff believed the system to have mandated an initiative that staff have not fully bought in to yet, the NM would say,

> 'Listen, we have to try this. We're going to identify barriers. You're going to communicate those with me. And all we can do is try. That's the only way to know if something is successful or not'. . . . She does openly say, 'okay, tell me more about what

> your problem is with that,' and so I feel less inclined to be agitated at her and more agitated at the system. Whatever that is.

The NM's ability to communicate openly and honestly reduced participants' inclination to place blame on the system for an initiative that may not have initially been well received and increased participants' buy-in.

Nurse manager supports and enables individuals and the collective team. Participants reported the NM was supportive of them as individuals and of them as a team, which promoted buy-in to unit initiatives. The NM encouraged professional growth and provided positive feedback that influenced desired performance. One participant described the NM's positive feedback as validation of the work she was doing and encouragement to continue the work. Participants reported the NM to be supportive even when expectations were not met. They never felt as if they were singled out for failure; rather, the team shared collective successes and failures. The NM offered to help through her physical presence, assisting with patient care duties, and through her collaborative approach to problem solving, seeking solutions from those who performed the work. Participants valued the NM's responsiveness and her physical presence promoted peace of mind. While infrequently present on night and weekend shifts, all participants reported the NM remained connected and was responsive, which enabled them to do the work of the unit.

Shared accountability for successes and failures. Participants reported staff and NM shared unit successes and failures and failure was an accepted component of any new initiative. The NM promoted failure as part of the change process. "There's been things that we've tried and that have failed, but [the NM's] ok with that because that's the process and we don't know that something is not going to work until we try it."

There was such a strong sense of shared accountability that participants reported they consistently performed to not disappoint their NM or peers. Participants attributed unit successes to the NM and felt accountable to her.

> Why [would] I want her to get in trouble for something that I could have done? . . . She never makes you feel like you're going to get in trouble. She just communicates it in a way that let's you see that it's important and that it means something to her. So you don't want to let her down.

When speaking to her NM's accountability to unit success, one participant reported the NM relied on staff as much as the staff relied on the NM. Shared accountability occurs when expectations are known. A participant noted he knew what the NM expected of him and he tried to meet and exceed those expectations.

Nurse manager seeks to understand and helps others to understand. Participants consistently reported the NM asked *why* and sought feedback. The NM would always make time to listen to them and when she listened, she was present and attentive. She also sought staff input when initiatives were not progressing as planned. One participant noted staff were able to share the things they were struggling with along with the things they were succeeding in. Participants reported they always felt they were heard because the NM sought their input. They also reported the NM explained the *why* behind the initiative. One participant articulated how the NM's approach to communicating change was received,

> She always tells you the *why*. So you always know the *why* behind why we're changing something. That really helps us as a team want to change or try out this new initiative. Because if you're hearing the *why* it just makes so much more sense [than] if you bring

> this implementation forward and [management's] just like, 'well, this is just what we're going to do now.'

Through the act of listening, the NM affirmed what she heard, set expectations, and asked staff how they could best achieve those expectations. When describing how frequent questioning impacted the team, a participant said, "you've got a whole bunch of people that are patient focused and really wanting to know the *why* behind all the answers, and not being satisfied with anything other than success and greatness." One participant reported the NM's questioning helped her to grow as a leader and pushed all staff to be more resourceful and think critically. Another reported the NM's ability to explain the *why* behind an initiative significantly increased buy-in.

Positive feedback reinforces behavior. According to one participant, "When you get positive feedback about something, it kind of makes me think, 'oh, that's working! I should probably keep doing that.'" When responding to a question about how she thinks or feels as she receives communication from her NM inquiring as to why a task was not completed, another participant stated,

> She does it in a way to make sure that you don't feel like. . . she's not punishing you. She's just wondering how to improve it. She's really good about asking. . . [about] the barriers and then to see what could have been to prevent that. She does it in a very approachable manner. She doesn't ever want to make you feel bad. She'll always start with saying, 'you're not in trouble, but I'm just curious as to why.'

A Nurse Manager-Facilitated Approach to Staff Led Decision-Making

Staff were responsible for implementing change through shared decision making with NM support.

Staff understand unit goals. Participants articulated unit goals and their role in achieving those goals. While patient experience was the phenomenon of interest, participants did not differentiate between patient experience initiatives and quality initiatives. Describing them as one in the same, one participant spoke to the importance of keeping patients' rooms clean and disinfected and keeping patients safe from hospital acquired infections. As he noted, if patients and families walked out of the hospital with an infection they received while hospitalized or while visiting a family member who was hospitalized, they were not going to be pleased with their experience. Participants valued feedback from the NM as it helped them to know how their performance affected unit goals. Nurse manager communication helped to affirm expectations so participants knew how to perform.

Staff drive the work of the unit with nurse manager support. Participants reported the presence of a shared decision making structure wherein nurses identified barriers, discussed how best to overcome those barriers, and implemented practice changes in support of unit goals. Participants identified that NM's rationale for being present at Practice Council meetings was to seek input, not to dictate or direct practice. Participants reported they did not resist change, recognizing the only way to achieve unit goals was to try something new.

> The idea, though, is that we're looking to see if we can do something just a little bit better. And if we can do that just a little bit better, maybe there's something else that will open up and have a better opportunity for change as well.

The NM set the framework wherein staff conducted the work of the unit and ensured staff understood her expectations. The NM was able to simplify initiatives, and participants reported the simplified initiatives were not as burdensome as complex initiatives and were easier to carry out. Participants reported not all staff were initially supportive when the NM introduced a new

initiative, yet staff knew the NM's expectations regarding the initiative were firm. According to a participant, "She was getting beat up like by everybody. . . telling her 'this is stupid. Why are we doing this?' And she just took it and said, 'well, we're doing it.'"

The NM would start a conversation about upcoming change by complimenting staff and expressing appreciation. She affirmed the change was not because staff had done something wrong; rather, she tied change to best practice evidence. She would ask staff to identify barriers and she anticipated questions. According to one participant, "She exudes excellence and encourages us to take the reins on things." Another participant noted, "I don't see her as directing us what to do or where to go. I see her asking us, you know, 'where is it that you want to go? Now let's go.'"

Peer interactions support unit work. Teamwork was vital to unit work and the manager facilitated an environment in which communication among peers was free and open. Communication among peers did not affect participants' decisions to participate or not participate in an initiative because the standard that the unit would frequently change in support of patients was set. Instead, their ability to communicate with each other allowed for brainstorming in support of alternative approaches to completing the work. A participant articulated the value of sharing ideas among peers,

> We all have really open communication. . . . Sometimes you'll find another person who has found a different way of doing something that works better. And that kind of trickles down and they share that with other people, and then we bring it back and re-discuss that initiative and how to. . . . change it to kind of adapt to be the best for the practice.

Participants reported they did not want to let each other down by not actively participating in a unit initiative. While discussing the occasional lamentation peers share with each other, a participant stated,

> Being able to have an open conversation with a peer, even though it is essentially a negative conversation, it allows them an opportunity to validate my feelings. . . But more importantly, it gives them the opportunity to correct my oversight or my misunderstanding.

Participants sought support from each other, yet rather than using communication opportunities to lament challenging work, they used communication to better understand how others were accomplishing the work. One participant may relay a challenge in a certain task and another participant would offer ideas that had worked for him or her to complete the work. Through communication, participants adapted practice in support of unit initiatives.

> I would say on our unit we are a tight enough group that we communicate well. . . We may complain, or we may be like in passing, 'this is so silly', or whatever, or but we just – we do it. We try to do it and do our best.

Discussion

Participants were actively engaged in unit initiatives because of the positive communicative relationship they had with their NM. Each of the three themes contained supportive categories that add to a limited body of knowledge of how NMs' communication with nurses is related to nurses' decisions to buy-in to organizational initiatives to enhance PEC.

The first question this research sought to answer was to identify activities participants undertook to enhance PEC. While leaders in most hospitals can articulate an activity like hourly rounding as an initiative to support patient experience, as did participants in this study, these

participants also described quality and patient safety-related initiatives as influencers on patient experience. This finding is important because nurse attention to quality and safety initiatives as influencers on the patient experience aligns with another finding that identified that patients who are not satisfied with their experience may also feel that their safety is compromised (Rathert, May, and Williams, 2011). Understanding how the NM's communicative relationship with staff influences the relationships among patient satisfaction initiatives, quality and safety initiatives, and patients' perceptions of care is a topic for future research.

The second research question sought to understand participants' descriptions and perceptions of NM communication and how their participation in initiatives changed based on NM communication. Participants described multiple methods wherein communication was exchanged between NM and staff, and all methods were identified as adequate. The sharing of data was also important to communicating messages and participants articulated the influence of the NM's transparency in sharing data to their continued engagement in initiatives.

The NM was a role model who was perceived to successfully influence change, positively influence unit culture, and had characteristics admired by participants. The NM's positive influence on change aligned with Prottas and Rogers Nummelin's (2018) findings that staff are more likely to be engaged in the work of the unit when they have a positive perception of their NM's behavioral integrity, defined as staff perception of what NMs say versus how NMs act. Participants perceived the NM's communication to align with her actions, insomuch as what was being asked of the participants by the NM would also be willingly carried out by the NM if needed.

The NM's influence on unit culture aligned with study findings that suggested the NM's ability to positively support working conditions resulted in engaged staff and improvements in

patient outcomes (Smith Lewis & Cunningham, 2016; Van Bogaert et al., 2017). The NM created and sustained an environment wherein participants felt safe communicating challenges and successes, and participants knew their NM expected them to communicate those with her. Similar to a study of NM behavioral traits that positively influenced nurse job satisfaction (Feather, Ebright, and Bakas, 2015), participants described how the NM as role model and the NM as a "good person" influenced their willingness to buy-in to initiatives.

A key finding that resulted in participants feeling supported was the NM consistently asking *why*. Each participant articulated the NM's genuinely inquisitive nature. The NM wanted to know what barriers participants experienced in implementing initiatives, and asking *why* was an effective approach to engaging participants in that dialogue. The NM's response to participants articulating concerns was equally appreciated. Participants felt they were heard and knew the NM would respond to what they said. Consequently, participants believed their NM to be an equal partner in the work of the unit.

Nurses in one unit perceived the NM to be a filter between system demands and the practicalities of implementing initiatives. This unit-specific category may, in part, be related to a lesser degree of Lean methodology integration into the unit when compared to the other unit that was identified by participants as the Lean model for the organization. Findings from one study suggested that when compared to nurses in a hospital that was an early adopter of Lean implementation, nurses in a hospital that was a later adopter of Lean implementation had fewer second-order problem solving responses (communicating about exceptions, finding and removing the root cause of a problem, and experimenting) (Gemmel, Van Beveren, Landry, & Meijboom, 2019). Regardless, the NM's approach to supporting participants, communicating openly and seeking feedback, was in alignment with themes found consistently in both units and

consistent with a study finding that suggested that the way a NM communicates influences a nurse's expectations regarding organizational change (Portoghese et al., 2012).

Participants articulated unit objectives and believed that they owned the professional practice of nursing on the unit with support of the NM. Participants did not feel the NM was directing them; rather, the NM was viewed as not just allowing, but also expecting, participants to identify and implement change to better integrate initiatives into unit workflow. Consistent among participants was the understanding that change was an expectation of professional practice. Rather than lamenting the change, participants described how both staff and NM used a shared decision making structure to understand what was expected, and within boundaries outlined by the NM, ensure the team carried out initiatives.

The final research question addressed how participants described conversations they had with their peers about NM communication and if those conversations influenced their participation in unit initiatives. Participants acknowledged communicating with each other about unit initiatives. Communication, however, did not center on the NM's communication regarding the initiative, a finding that suggests participants were satisfied with NM communication and had no need to complain about how or what the NM was communicating regarding the initiative. Rather, participants communicated with each other from the perspective of seeking or offering support. When one participant communicated obstacles to successfully completing an initiative, his peers would contribute ways in which they were able to successfully complete the initiative, which allowed the participant to change his practice. Participants were driven to perform because they saw their peers perform, a finding that aligned with another study (Prottas & Rogers Nummelin, 2018). Peer communication structured how an initiative was actualized and

reshaped the initiative each time participants shared ideas with each other to more effectively conduct the work.

Limitations

First, interviews occurred approximately two weeks before the hospital's participation in a highly advertised standardized survey of nurse satisfaction that may have heightened nurse interest and subsequent participation in the study as an additional form of his or her voice being heard. Second, Lean implementation is an important consideration in analysis and interpretation of the data; one unit in this study was further along in the Lean implementation process and therefore may explain differences between the two units in regards to the NM as system filter. Finally, some participants were contacted by their NM to consider participating, which may have influenced their willingness to participate.

Conclusion

The aim of this study was to understand how nurse NMs' communication with nurses related to nurses' decisions to buy-in to organizational initiatives to enhance PEC. Findings from two inpatient medical-surgical units of a large acute care hospital that had achieved a HCAHPS four-star summary rating for PEC suggest that nurses who describe a strong communicative relationship with their NM are more willing to buy-in and be engaged in these initiatives. The communicative relationship was developed and strengthened through the NM's use of multiple methods to communicate and influence change, engaging and supporting staff, and promoting staff-led decision making.

Implications for Nursing Management

Nursing leaders and hospital executives can benefit from understanding how communicative relationships affect performance in an age of increasing complexity in

healthcare. Data drive organizational performance, yet the work of nurses drives data. Leaders expect nurses to perform, and a close assessment of the relationship between the frontline nurse NM and his or her team may reveal why initiatives to support PEC may or may not yield desired results. Hospital executives also have an opportunity to allocate financial resources so that communication-related training opportunities are available to NMs. Additional research is needed to identify the strength of communicative relationships in hospitals that do not have high ratings for PEC.

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CHAPTER 4

The Power of Communication: The Nurse Manager's Capacity to Influence the Environment in which Patients Experience Care through Communication with Nurses

Abstract

Objective

To synthesize the literature and provide research-informed actions nurse NMs should consider so nurses may positively perceive NM communication.

Background

Little is known about how a NM's communicative relationship with nurses relates to PEC.

Methods

A review of the literature was conducted to identify the role of NMs' communicative relationships with nurses to PEC. Eight articles were analyzed. Recommended actions for NMs were developed from interviews with nurses (n = 15) at a large hospital that had achieved a high rating for PEC.

Results

Leader characteristics, influence on the environment, and leadership styles were related to PEC. NMs should: (a) be present and engage; (b) provide consistent, clear, and relevant communication; and (c) empower staff to own their professional practice, and then let them lead.

Conclusion

Additional research is needed to better understand the role of NMs' communicative relationships with nurses to PEC.

Issue

Effective communication is one of the most valuable skills for healthcare leaders in an age of increasing complexity in healthcare (Anderson, Manno, O'Connor, & Gallagher, 2010; Crow, Hahn, & French-Bravo, 2019; Hicks, 2011). Communication is vital to an organization and influences the relationships the organization's leaders have with clinicians and with patients. For decades, patients have recognized problems associated with ineffective communication resulting in uncoordinated care and an overall poor experience (Beaudin, Lammers, & Pedroja, 1999). Oftentimes, effective communication can become muddled in a healthcare organization's increasing myriad of priorities resulting from expectations of payors, patients, and providers, and regulators.

One priority, PEC, is ever present as it can be observed in each interaction a clinician has with a patient or family member; heard via complaint or compliment call; or read in patient satisfaction and comment data, on Twitter, or on Facebook. A hospital's capacity to have high ratings for PEC depends on a leader's ability to effectively communicate the hospital's goals to those providing care, yet leaders can miss opportunities to understand patients' experiences when leaders fail to engage staff who regularly interact with patients (Balik, 2011).

Leaders recognize that in an environment where perceived value drives reimbursement, staff engagement via a healthy work environment supportive of a culture of effective communication is vital to an organization's outcomes (Decker, Mitchell, & Rabat-Torki, 2016). What research has not yet fully examined is how the leader's communicative relationship with a nurse relates to PEC. The purpose of this study was to: (a) synthesize the literature regarding the role of hospital-based NMs' communicative relationships with nurses to PEC, and (b) provide

recommendations for NMs to enhance how they can positively influence nurses' perception of NM communication.

Methods

A review of the literature was conducted to identify the role of hospital-based NMs' communicative relationships with nurses to PEC. Electronic searches were performed in PubMed, CINAHL, and ProQuest for literature published January 2009 to March 2019. Internet searches using Google and Google Scholar were also conducted. Keyword combinations of manager, leader, communication, discourse, patient satisfaction, and patient experience using the "AND" and "OR" operators were used to identify a wide-array of literature suitable for review. Publications presented by PubMed and ProQuest as "similar articles" and potentially relevant were reviewed. Both peer and non-peer reviewed publications were considered for inclusion if they addressed a relationship (whether anecdotal or researched, direct or indirect) between NM communication with nurses and PEC. Systematic literature reviews were included if the literature were published between the aforementioned publication period. Articles with non-adult patient populations and those identified as not hospital based were excluded.

Results

Titles of 722 publications identified during the initial database search of the literature were reviewed for duplication and relevance and 655 publications were excluded because they clearly were not related to communication and PEC or satisfaction (Figure 4.1). Abstracts of the remaining 67 publications were further screened for relevance and 33 were excluded because they did not include a direct or indirect relationship between manager or leader communication and PEC or satisfaction. A full publication review was conducted for the remaining 34 publications.

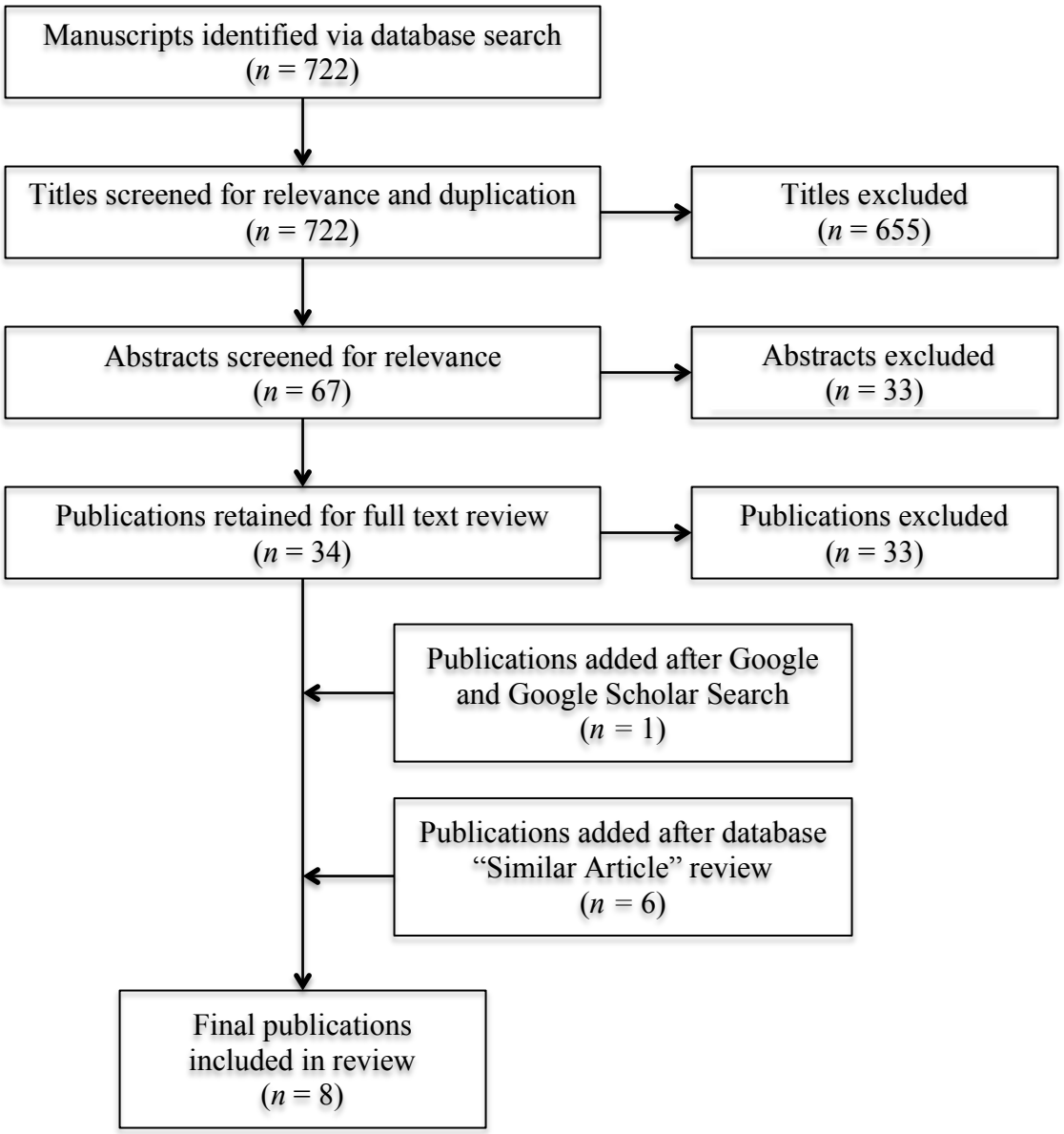

Figure 4.1. Literature review and selection process

After careful assessment, 33 publications were excluded because they did not contribute knowledge to understanding how the manager or leader's communicative relationship with the nurse influenced PEC or satisfaction. Six additional publications presented as "similar articles" during the database search were analyzed and retained. One publication identified during a

Google and Google Scholar search was also analyzed and retained. The final analysis included eight publications (Table 4.1).

Leader Characteristics

Adams, Djukic, Gregas, and Fryer (2018) conducted a multi-state study to understand the relationship between nurse leaders' self-reported personal and practice characteristics and their influence on nurse-sensitive patient outcomes, including patient satisfaction. Nurse leader characteristics included collegial administrative approach, internal strategy and resolve, authority, access to resources, leadership expectations of staff, and status. Assessed within the characteristic of leadership expectations of staff was the expectation that staff hold each other accountable for professional practice of individuals and the team and have the authority to act (Adams et al., 2013). This characteristic is important because effective communication is required for a leader to create an environment in which self-governance and accountability thrive (Moore & Hutchison, 2007).

Findings suggested a nurse leader's expectations of staff were directly and positively correlated with patient satisfaction (Adams et al., 2018). While the nurse leader's ability to influence patient outcomes via the work environment is known (Aiken et. al., 2012), this research is the first to offer empirical evidence of how specific nurse leader communication-related characteristics may influence patient satisfaction.

Leader Influence on Work Climate

Findings from Ancarani, Di Mauro, and Giammanco's (2011) study suggested a positive relationship between patient satisfaction and the manager's ability to influence the work climate by promoting autonomy, including staff in decision making, ensuring supervisors support staff,

emphasizing development of skills, and caring for staff welfare, all actions that require effective communication.

Table 4.1

Literature Review Matrix

Author et al. (year)	**Design/ Level of Evidence[1]**	**Sample/ Setting**	**Aim of the Study**	**Outcome Definitions**	**Key Communication -related Patient Satisfaction Findings**
Adams et al. (2018)	Cross-sectional, Correlational/VI	35 US hospitals. 778 nurse leaders.	To examine the relationship between nurse leaders' self-reported practice characteristics and patient outcomes	**Leader Characteristics** Leadership Influence over Professional Practice Environments Scale (LIPPES) **Patient Satisfaction** Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) *RN communication *MD communication *Staff responsiveness *Room cleanliness *Noise	**Nurse leader authority** associated with RN communication (r = 3.7, p = .046), room cleanliness (r = 5.22, p = .014), and noise (r = -20.48, p = .048) **Internal strategy and resolve and access to resources** associated with MD communication (r = 24.07, p = .042) and (r = 16.04, p = .002) respectively **Leadership expectations of staff** significantly associated with

[1] See Melynk and Fineout-Overholt's (2011) Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions, p. 12.

Author et al. (year)	Design/ Level of Evidence[1]	Sample/ Setting	Aim of the Study	Outcome Definitions	Key Communication -related Patient Satisfaction Findings
					RN communication (r = -3.155, p = .002) and room cleanliness (r = -32.51, p = .008) but moderated by years of current practice experience
Ancarani et al. (2011)	Descriptive, Cross-sectional/VI	57 managers, 621 nurses, 277 physicians, and 1,598 patients in 10 Italian hospitals	To test a model in which patient satisfaction is influenced by staff perception of the work climate as established by the manager	**Employees' Perception of Climate and Managers' Climate Orientation** Adapted Organizational Climate Measure (OCM) that assesses Human Relations (HR), Open Systems (OS), Rational Goal (RG), and Internal Process (IP). **Patient Satisfaction** Adapted SERVQUAL questionnaire with 5 scales (tangibles, reliability, responsiveness, assurance, empathy)	(a) The HR climate (employee autonomy, involvement in decision making, supervisory support, training, and employee welfare) plays a role in increasing patient satisfaction (b) Managers' orientation on the climate measures does not directly impact patient satisfaction (c) How employees perceive the work climate fully mediates patient satisfaction and managers' climate

Author et al. (year)	Design/ Level of Evidence[1]	Sample/ Setting	Aim of the Study	Outcome Definitions	Key Communication-related Patient Satisfaction Findings
					orientation
Boev (2012)	Secondary data analysis of longitudinal data/VI	671 nursing and 1,532 patient surveys obtained from a large US hospital	To identify patients' perceptions of ICU nursing care, described nurses' perceptions of the ICU work environment, and identify relationships between nurse perception of work environment and patient satisfaction	**Employee Perceptions of the Work Environment** Practice Environment Scale of the Nursing Work Index (PES-NWI) **Patient Satisfaction** Ingersoll's Intensive Care Unit Patient Satisfaction Survey	Nurse perception of nurse manager leadership and ability was significantly related to patient satisfaction ($p = .018$)
Daniel (2010)	Descriptive, Cross-sectional/VI	67 supervisors and 131 non-supervisors in 2 US hospitals	To identify how leadership styles are associated with patient satisfaction	**Leadership Styles** Multi-factor Leadership Questionnaire (MLQ) Leader-member Exchange – Multidimensional Model (LMX-MDM) **Patient Satisfaction** HCAHPS	Positive associations between Transformational Leadership and all HCAHPS variables The higher the level of interactions between leaders and subordinates the more positive the interactions between subordinates and patients

Author et al. (year)	Design/ Level of Evidence[1]	Sample/ Setting	Aim of the Study	Outcome Definitions	Key Communication-related Patient Satisfaction Findings
Mäntynen et al. (2014)	Mixed-method, longitudinal /VI	Varying sample of nurses and nurse leaders in 1 Finnish hospital	To describe post-intervention changes in transformat-ional leadership and patient outcomes from 2008 to 2010	**Leadership Style** Transformational Leadership Scale (TLS) **Patient Satisfaction** Revised Human Caring Scale (RHCS)	Efforts to enhance transformational leadership resulted in an overall mean score increase from 3.34 in 2008 to 3.39 in 2010. Findings were significant for multiple factors including teamwork ($p <$ .001) and participation in decision-making ($p = .007$) The difference in patient satisfaction scores measured in 2008 and 2010 was both positive and significant ($p =$ .023)
Mazurenko et al. (2019)	Secondary data analysis of cross-sectional data/VI	5,919 managers and 39,512 clinicians in 181 hospitals across the US	To identify how agreement between managers' and clinicians' perceptions of patient safety climate relates to patient satisfaction	**Patient Safety Climate** Hospital Survey on Patient Safety Climate **Patient Satisfaction** HCAHPS Survey *RN Communication *MD Communication	Patient satisfaction with: (a) RN communication was positively and significantly associated with high levels of communication openness ($\beta = 2.25$, $p <$ .01), teamwork

Author et al. (year)	Design/ Level of Evidence[1]	Sample/ Setting	Aim of the Study	Outcome Definitions	Key Communication -related Patient Satisfaction Findings
				*Communication about Medicines *Discharge information	across unit (β = 2.91, p < .001), and feedback and communication about errors (β = 3.0, p < .001) (b) Discharge information was positively and significantly associated with high levels of communication openness (β = 2.37, p < .05) (c) Communication about medicines was positively and significantly associated with high levels of communication openness about patient safety (β = 2.46, p < .05), feedback and communication about errors (V = 2.89, p < .01), and teamwork across units (β = 3.34, p < .01)

Author et al. (year)	Design/ Level of Evidence[1]	Sample/ Setting	Aim of the Study	Outcome Definitions	Key Communication -related Patient Satisfaction Findings
McCay et al. (2018)	Systematic literature review/V	14 articles using quantitative measures published between January 2009 and September 2016	To understand if relational or task oriented leadership styles relate to nurse and patient satisfaction	Varied based on the study	There were no quantitative findings demonstrating the effects of leadership style of patient satisfaction
McCutcheon et al. (2009)	Descriptive correlational /VI	41 managers and 717 nurses in 7 US hospitals	To examine the relationships among leadership style, leader span of control, nurses' job satisfaction, and patient satisfaction	**Leadership style** Multifactor Leadership Questionnaire **Job Satisfaction** McCloskey-Mueller Satisfaction Scale **Patient Satisfaction** Patient Judgments of Hospital Quality Questionnaire	Patients were more satisfied on units with leaders who demonstrated a transactional leadership style ($p < .01$)

That relationship, however, was fully mediated by staff perceptions of the work environment. In other words, how staff perceived the manager's ability to influence the work climate is what

influenced patient satisfaction. Similar results were identified in the intensive care unit setting (Boev, 2012).

Mazurenko, Richter, Swanson Kazley, and Ford (2019) identified the relationship between patient satisfaction and how well hospital-based managers and clinicians agreed on the safety climate in their hospitals. Safety climate variables included feedback communication about errors, teamwork across units, teamwork within units, and communication openness. The researchers concluded that higher patient satisfaction scores were experienced in those hospitals where managers and clinicians both perceived the safety climate as high or only clinicians perceived the safety climate as high. In other words, patients were more satisfied in hospitals where managers and clinicians both agreed that high levels of teamwork and communication were present.

Leader Management Style

Daniel (2010) sought to better understand the relationship between leadership style, a leader's behavioral characteristics employed to lead staff to a common goal, and patient satisfaction. Transformational leadership was identified as the predominant leadership style and had a positive association with patient satisfaction. Mäntynen et al. (2014) found that when efforts are made to develop transformational leadership over time, patient satisfaction is also positively influenced. McCutcheon, Doran, Evans, McGillis Hall, and Pringle (2009) conducted a similar study with contrasting findings. The researchers identified a significant positive relationship between a transactional leadership style and patient satisfaction.

McCay, Lyles, and Larkey (2018) conducted a systematic review of the literature to identify relationships among nursing leadership styles, nursing staff outcomes, and patient satisfaction. While associations were found among nurse leadership styles and nursing staff

outcomes, the authors were unable to identify quantitative findings specific to nursing leadership styles on patient satisfaction in acute care hospitals and noted this gap in the literature warranted further assessment.

The relationship of a NM's leadership style to PEC is important to understand given the criticality of communication to both the NM's expression of leadership style and nurse interpretation of that expressed style. Clear communication is a critical aspect of transformational and transactional leadership styles (Hicks, 2011), yet not all studies identified a relationship between leadership style and PEC. Additional research is needed to clarify how communication components of leadership styles influence PEC.

Limitations

Communication and its relationship to PEC is a valuable yet understudied area of research for nursing administration. Articles excluded in this review addressed communication-related aspects of leadership in relationship to staff commitment and retention (Brunetto et al. (2013), organizational citizenship behaviors (Cullen & Gordon, 2014), the professional practice environment (Ducharme, Bernhardt, Padula, & Adams, 2017), the leader's perception of communication and its influence on unit culture (Hartung & Miller, 2013), and unit culture (Ma, Shang, & Bott, 2015). The dearth of included articles in this review of the literature is a significant limitation and indication that additional research is needed to understand the role of the NMs communicative relationship with nurses to PEC.

Recommendations for Nurse Managers

One way to assess the communicative relationship between NMs and nurses is to engage nurses who provide care in order to understand how their NM's communication influences their participation in initiatives that support PEC. The remainder of this manuscript will explore two

inpatient units in a large acute care, Magnet-designated hospital in the Midwestern United States that had achieved a high level of patient satisfaction. The setting was part of a qualitative study to assess how nurses' perceptions of NMs' communication influenced their willingness to buy-in to initiatives to support PEC (French-Bravo et al., 2019).

Findings of French-Bravo et al.'s (2019) study will add to what little is currently known about how the NM's communicative relationship relates to PEC. A synthesis of those findings from nurse interviews (n = 15) informs three recommendations for NMs to enhance how nurses perceive NM communication: (a) be present and engage staff; (b) provide consistent, clear, and relevant communication; and (c) empower staff to own their professional practice and then let them lead. Table 4.1 provides action steps for each recommendation. These recommendations and actionable steps are offered from the context of the positive perception each interviewee in French-Bravo et al.'s study had of his or her NM's communication.

Be Present and Engage

A NM's presence is important to effectively communicating with staff. While physical presence in the form of rounding is one way to be present, staff also value other demonstrations of presence. For example, an NM who responds to email, phone calls, and text messages in as real-time as possible during work hours creates a feeling of virtual presence for the staff member. Recognizing that NMs' health, wellbeing, and work-life balance is crucial to their work, NMs should also advise if there are known limitations to a virtual presence. For example, the NM may advise staff to contact the charge nurse during off hours for routine assistance and that after-hours contact occur via phone call only for emergencies that the charge nurse is unable to rectify.

Table 4.2

Recommendations and Action Steps

Recommendations	Actions
1. Be present and engage	• Promptly respond to all staff inquiries (email, text, in-person) • When on the unit, acknowledge and make eye contact with each staff member – every time. • Always seek to understand from the perspective of staff by asking 'why' • Know and be able to recall one personal characteristic of each staff member (e.g., the name of a child graduating, a spouse starting a new job, a non-work related activity the staff member is involved in) • Mentor charge nurses so that staff view them as an extension of the manager
2. Provide consistent, clear, and relevant communication	• Create a visual display of key unit metrics • Regularly update the display with results and advise staff when they can expect the display to be updated • Disseminate patient satisfaction comments – both positive and negative – each time the report is received • Publicly recognize staff who are mentioned by name in positive comments (email, staff meetings, huddles) • Privately engage staff who are mentioned by name in negative comments. • Demonstrate how data drive decisions • Always articulate the 'why' behind the change
3. Empower staff to own their professional practice, and then let them lead	• Create a shared governance structure • Ensure up-to-date data are available so that staff can make data-informed decisions • Advise staff of problems to be solved and ask how they would recommend solving the problem • Allow staff-led decisions to succeed or fail • Encourage staff to communicate with each other when staff identify a barrier to successful completion of an initiative

When physically present, the NM should make every attempt to personally engage with each staff member working. That face-to-face interaction allows staff an opportunity to clarify expectations, communicate concerns, and offer suggestions. The encounter is an excellent

opportunity for a NM to seek to understand from the staff member's perspective. Physical presence can be challenging given the multiple meetings and other off-unit requirements, and administrators should consider how to minimize NM time away from the unit so that NMs can be present with and engage their staff.

The face-to-face interaction also allows the NM an opportunity to engage the staff member on a personal level. Staff are more likely to positively perceive communication from the NM when they believe the NM knows them as people outside of work. Recollecting a recent vacation, inquiring as to a child's recent soccer match, or asking how pottery lessons are progressing are all ways a NM can build a relationship by engaging staff on a personal level, particularly with those nurses who prefer one-on-one rather than group recognition.

Finally, staff leaders (e.g., charge nurses) can be perceived as extensions of the NM and an important substitute for the NM's presence when he or she is unavailable (French-Bravo et al., 2019). Engaging charge nurses in unit planning activities, providing leadership development opportunities, and mentoring on effective communication techniques are all approaches a NM can take to ensure that charge nurses are consistent in their approach to meeting unit objectives in the absence of the NM. In the absence of full engagement, charge nurses may not have the skillset to positively and productively engage associates who raise concerns about work or are lamenting an initiative.

Provide Consistent, Clear, and Relevant Communication

The sharing of data is one critical form of communicating information. Staff want to know if and how their activities influence initiatives. The consistent sharing of data in a

staff accessible work space (e.g., break room) is an action NMs must take to keep staff informed. Other methods of sharing data (e.g., email, printed newsletter) can also be used, but all staff should be able to visualize the data in one consistent space to ensure a shared understanding of progress. The shared data should be clear (i.e., unit specific) and relevant (i.e., timely and specific to the initiative) if staff are to perceive the data as meaningful to their work. A simple graph that plots unit-specific patient satisfaction results over time can be used as a visual display. A table of positive and negative comments from patient satisfaction comments is another way to display data. Inform staff of how frequently they should expect to see the data updated. For example, if patient satisfaction comments are delivered via email to the NM at 8 a.m. each Monday, advise staff that they will see the display updated by 8 a.m. each Tuesday.

Communicate not only what is working, but also what is failing (French-Bravo et al., 2019). Staff value public recognition for individual successes and private conversation for individual improvement opportunities. For example, a nurse who is mentioned by name in a positive feedback comment should be recognized publicly (e.g., staff meetings, huddles, unit-wide email communication, hospital newsletter, unit or hospital intranet site). Likewise, each time an individual is named in a negative feedback comment is an opportunity to seek to understand from the staff member's perspective in a safe, private place. Be consistent in communicating success and failures. Staff have a positive perception of NM communication when the message (e.g., sharing of data) is consistent in frequency and comprehensive in content.

Staff positively perceive NM communication when the NM articulates the 'why' behind a new initiative and substantiates the 'why' with data (French-Bravo et al., 2019). There will always be organization-initiated mandates in hospitals (e.g., implementing hospital-wide hourly rounding to enhance PEC). A NM's ability to explain why the hourly rounding initiative is

relevant to patients cared for on that unit and justify the initiative with data will increase staff willingness to buy-in to hourly rounding.

Empower Staff to Own Their Professional Practice, and Then Let Them Lead

Staff positively perceive NM communication when they know the communication is informed by a staff-led shared decision making structure. Staff will own their professional practice when empowered to do so. Commonly referred to as shared decision making or shared governance, the purpose of a unit-specific staff-led practice council is to ensure evidence-based, patient population-specific, initiatives aligned with the organization's strategic plan and financial restrictions are implemented by those most familiar with the work. One can look to Porter-O'Grady's (1992) classic work in shared governance for guidance on creating a staff-led shared decision making structure and to Crow, Hahn, and French-Bravo (2019) for leading staff-led shared decision making in a complex healthcare environment.

Just as NMs should regularly present data to demonstrate progress and substantiate new initiatives, so, too, should NMs provide data for staff to make informed decisions. NMs should not only provide the data but also expect staff to demonstrate how decisions made within shared decision making were informed by data. The shared decision making structure is a collaborative space where the NM can bring a problem to be solved, seek staff ownership of steps to resolve the problem, and inform staff of potential limitations that may influence their work (e.g., financial restrictions, regulatory requirements).

A relationship built on strong communication is further solidified when the NM empowers staff to carry out the activities as created in the shared decision making structure. One sure way for a NM to impair communication is to facilitate staff-led decision making and then not allow those decisions to be implemented into practice. If staff have identified solutions to a

challenge (e.g., implementing hourly rounding to enhance PEC) within the framework of limitations as previously outlined by the NM, then the NM must allow the process to continue. Progress is identified through both successes and failures, and the NM should create an environment wherein both are equally valued and thoroughly discussed.

One way to support an environment for safe communication is to intentionally ask what has worked and what has not worked during each staff gathering (e.g., staff meetings or huddles). Asking staff to articulate success and failures allows other staff to offer solutions. Similar to an example offered by a nurse in French-Bravo et al.'s (2019) study, during huddle one staff member may express frustration with a patient who always wants something out of his belongings bag each time the staff member rounds. Another staff member offers that he had a similar problem last week and found that by setting up the bedside table at the beginning of the shift with items that the patient thought she might need throughout the day, his time spent in the room each hour decreased.

Conclusions

Leaders must recognize the power of effective, consistent communication in establishing relationships. Staff look to NMs to create the environment in which staff feel their communication is heard (Garon, 2012), yet NMs recognize that communication is a journey that requires continual refinement (Hartung & Miller, 2013). While few research studies have been conducted that demonstrate the relationship between NM communication and PEC, findings from French-Bravo et al.'s (2019) support specific actions NMs can take so that nurses positively perceive their communication and buy-in to initiatives that support quality and satisfaction goals. By being present and engaging staff; providing clear, consistent, and relevant communication;

and empowering staff to own their professional practice through a shared decision making structure, NMs will be in a better position to achieve higher scores related to PEC.

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CHAPTER 5

Summary

Manuscript Fit

This dissertation explored how the communicative relationship between nurses and NMs relates to nurses' willingness to buy-in to initiatives to support PEC. The three aims of the dissertation were to: (a) understand how the process of structuration through discourse may support an environment in which nurses want to buy-in to organizational initiatives that support PEC; (b) understand how nurses' perceptions of their NMs' communication relates to their buy-in to hospital initiatives to support PEC, and (c) use the findings to provide recommendations to NMs as to how they can positively influence PEC through communication with nurses they lead. Dissertation aims were investigated and reported through three manuscripts.

The first manuscript was an exploration of how structuration through discourse served as a foundation for nurse buy-in to initiatives. Gidden's (1984) Structuration Theory served as the framework to analyze structuration through discourse. An analysis of the literature was offered to identify the relationship of buy-in and discourse to organizational change. A hypothetical scenario was introduced to describe how components of Gidden's Structuration Theory are integral to nurse buy-in to initiatives. The process of structuration informed the analysis and interpretation of findings in manuscripts two and three.

The second manuscript used a qualitative descriptive study to explore how NMs' communicative relationships with nurses in a large acute care hospital in the Midwestern United States related to nurses' willingness to buy-in to organizational initiatives intended to enhance PEC. The hospital was selected because of its demonstration of high scores related to PEC. Three themes were identified that strengthened the communicative relationship between nurse and NM. The third manuscript used themes from manuscript two to craft specific actions NMs should take so that nurses more positively perceive NM communication. Additionally, the third

manuscript offered a synthesis of a review of the literature to identify the role of the NM's communicative relationship with nurses to PEC. Collectively, the three manuscripts add to the limited body of knowledge of how communicative relationships between NMs and nurses relate to nurses' willingness to buy-in to organizational initiatives that support PEC.

Summary of Results

Manuscript 1

The purpose of Manuscript 1 was to explore how the process of structuration through discourse shaped nurses' buy-in to organizational initiatives. An analysis of the literature demonstrated how both buy-in and discourse are integral to organizational change (French-Bravo & Ford, 2019). Deconstruction of Gidden's (1984) Structuration Theory identified that how nurses communicate with each other about their work *is* the social system in which they conduct their work, but that communication also *continually shapes* the social system where they work. The hypothetical scenario was an exemplar of how structuration through discourse is integral to nurse buy-in to organizational initiatives. How nurses communicate with each other and how the organization communicates with nurses influences nurses' willingness to buy-in to organizational initiatives.

Manuscript 2

The exploratory qualitative descriptive study presented in Manuscript 2 was informed by French-Bravo and Ford's (2019) (Manuscript 1) findings and sought to understand how a NM's communication with nurses related to nurses' decisions to buy-in to organizational initiatives to enhance PEC. Three themes emerged from analysis of interviews with 15 nurses in two medical-surgical inpatients units in a large acute care, Magnet-designated hospital in a Midwestern U.S. metropolitan area; observation of staff meetings; assessment of field notes, and analysis of other

artifacts including emails and digital presentations. The three themes were: (a) multimodal approach to communicating and influencing, (b) facilitating change through staff engagement and management support, and (c) a NM-facilitated approach to staff led decision-making (French-Bravo et al., 2019).

Participants described multiple ways their manager communicated and influenced change, which subsequently influenced their buy-in to PEC initiatives. The act of communicating occurred via varying modalities (e.g., in-person, visual displays, staff meetings, one-on-one meetings, email, text messaging), and the frequent sharing of data by the NM allowed participants to understand the results of their efforts to enhance PEC. The NM was perceived to be a role model with desired characteristics who positively influenced change through development of personal and professional relationships with staff. Unit culture was positively influenced through the NM's ability to create a safe environment in which ideas and questions could be shared and all were accountable to the unit's successes and failures.

Changes associated with initiatives to enhance PEC were facilitated through the manager's ability to engage and support staff, thus promoting their buy-in to initiatives. In one unit the manager was described as a filter between the system and nurses, translating system expectations for staff and allowing them to communicate their concerns openly, honestly, and safely. Participants described how the NM was supportive of them as individuals, knowledgeable of both their professional aspirations and personal challenges, and supportive of the collective team, with all team members sharing successes and failures. Continually seeking to understand by asking *why* as well as explaining the *why* behind the initiatives was another approach the NM used to engage and support staff.

The final theme involved the NM's facilitation of staff led decision-making. Staff in the unit were responsible for implementing change. They understood unit goals and the NM expected them to identify barriers to success, identify how to overcome those barriers, and implement change in support of unit goals. Staff ownership of their professional practice was successful because the NM set the framework in which staff could conduct their work by setting clear expectations, simplifying initiatives, and never veering from a patient-centric focus. Staff led decision-making was also supported by staff openness in communicating with each other, encouraging each other to share what was working and what was not. Staff communication resulted in adaptations to initiatives to enhance PEC and also continually refined those initiatives. All nurses in this study spoke positively of the communicative relationship they had with their manager, which in turn made them want to engage and buy-in to initiatives to enhance PEC.

Manuscript 3

The purpose of Manuscript 3 was to: (a) synthesize the literature regarding the role of NMs' communicative relationships with nurses to PEC, and (b) provide recommendations and action steps that NMs should take so nurses more positively perceive their communication. The recommendations and action steps were informed by a synthesis of French-Bravo et al.'s (2019) study findings (Manuscript 2). Only eight articles were included in the final review of the literature after sorting through 722 manuscripts initially identified. A literature review matrix was provided (see Table 4.1 p. 91).

One professional characteristic of a leader, setting the expectation that staff hold each other accountable, was a communication-related factor that influenced PEC. A leader's influence on the work environment (e.g., communicating about errors, promoting teamwork,

facilitating communication openness, caring for staff, promoting autonomy, ensuring support, including staff in decision making) as perceived by staff was another factor identified. The review of the literature also identified relationships between a leader's management style (e.g., transformational, transactional) and PEC. This is an important topic for future research given the role of communication to leadership styles (Hicks, 2011).

Based on a review of the literature and a synthesis of findings from French-Bravo et al.'s (2019) study (Manuscript 2), the following recommendations were made for NMs so nurses more positively perceive their communication: (a) be present and engage; (b) provide consistent, clear, and relevant communication; and (c) empower staff to own their professional practice, and then let them lead. Specific action steps NMs should take to achieve each recommendation were provided (see Table 4.1, p. 107).

Strengths

A significant strength of this dissertation was its capacity to add to a very limited body of nursing knowledge of how NMs' communicative relationships with nurses relates to PEC. Nursing research thus far has focused on the influence of the nurse leader on nurse outcomes (e.g., retention, nurse satisfaction, nurse commitment, organizational citizenship behaviors) and the impact of the nurse on patient outcomes (e.g., quality, safety, satisfaction). The communicative relationship between nurse and NM and its relationship to PEC is not well studied. Given the limited body of knowledge, the qualitative descriptive approach used in this study was also a strength; it facilitated an understanding of the phenomenon from the perspective of study participants, thus allowing an analysis of results to reflect the voice of the participant rather than a complex interpretation by the researcher (Sandelowski, 2000).

The level of engagement of participants of the in-person interviews allowed the researcher to not only hear but also visualize via animated gestures and facial expressions how valuable they perceive their communicative relationships to be with their NM. The majority of participants were very eager to share their positive experiences, and the ease of access to participants and their willingness to share was a strength. The triangulation of data (e.g., multiple interviews, staff meeting observations, emails, PowerPoint presentation), member checking, and peer debriefing added credibility to the dissertation findings.

Limitations

This study included only two nursing units from one hospital; thus, findings may not be generalizable to other nursing units or hospitals. There were systematic process improvements embedded within the hospital (Lean implementation and Magnet designation) that could be contributing factors to PEC, yet this study was solely focused on the NM's communicative relationship with the nurse and how that relationship related to patients' experience with care. Lean and Magnet designation may have contributed to the positive communicative relationships experienced by nurse participants in this study. The communicative relationship may look different in a hospital with lower PEC scores; however, the aim of this study was to understand nurse buy-in to initiatives from the perspective of nurses working in a hospital that had evidence of (i.e., high PEC scores) of being supportive of PEC.

Implications for Practice and Future Research

An organization's people, policies, and procedures are not independent phenomena. Rather, as constituents of the social system, each is continually shaped by the other. The study findings support that the way nurses communicate with their NMs and with each other about initiatives to enhance PEC is how those initiatives live within the unit and also continually

shapes how those initiatives are sustained, adapted, or forgotten. Structuration as a focus of nursing research is virtually non-existent, yet understanding how actions and inactions are structured within organizations through discourse may offer additional insights into how communicative relationships influence organizational outcomes.

How NMs communicate with nurses matters, as it influences nurse buy-in to initiatives. This is a relatively simple concept, yet the act of communicating is given far less attention in healthcare than the consequences of effective and ineffective communication. This study explored the act of NM communication as perceived by the nurses. Nurses are the conduit through which organizational initiatives are actualized at the bedside, and NMs are the conduit through which an organization's initiatives are interpreted by nurses. The NM in one unit of this study was perceived to be a filter between the frontline nurses and the larger hospital system. As such, future research should examine the communicative relationship between nurses and those higher up in the organization (i.e., nursing directors, CNO), and how that relationship, perhaps mediated by the NM, influences buy-in.

The level of enthusiasm and regard nurses in this study had for their NM was based on strong communicative relationships. Consequently, nurses in the study would do almost anything to stay actively engaged in initiatives to not disappoint their NM. The themes and categories explored in French-Bravo et al.'s (2019) study (Manuscript 2) offer insight into why study participants were so engaged. One action step offered by French-Bravo, Nelson-Brantley, and Williams (2019) (Manuscript 3) was for NMs to continually seek feedback by asking *why* and always explaining the *why* behind any initiative as it is introduced. Nurses in the study felt that their NM was genuine, as she constantly sought their feedback to identify what was working for staff and what was not. Nurse participants in this study bought in to initiatives because they

valued the NM's ability to explain why an initiative was being introduced and her openness to feedback from staff on how the initiatives could best be implemented in the unit.

Nurse managers should take the time to listen and explain. Ask staff what is working for them and what is not and then listen to their responses. An organization's goals will be more robustly supported when a leader seeks to truly understand from the perspective of those who are doing the work. Staff will be candid if provided an opportunity and in an environment where dialogue is encouraged. Staff will know best how initiatives should be actualized at the bedside, and if allowed to lead change in support of professional nursing practice, they will.

Nurse managers should set the framework wherein staff decisions can be made and then let staff lead that change. Nurse managers should take the time to explain why organization-mandated initiatives are being implemented by tying the initiative to unit-specific results (e.g., patient satisfaction scores, fall rates, other unit-specific quality indicators). Painting the picture of why the initiative is important to the patients on the unit and then seeking feedback from nurses on how to implement the initiative will be more positively received than simply dictating to nurses that they must add yet another task to their already busy day.

Nurse executives in healthcare are in the best position to advocate for and allocate resources in support of productive communicative relationships between NMs and nurses. Participants in this study valued the face-to-face dialogue with their NM. Those in-person interactions should be carefully balanced with administrative functions the organization requires of its NMs, such as meetings and tasks that require the NM to be away from the unit. Less time away from the unit is more time the NM has to actively engage staff. Providing financial resources for team-building exercises, after-hours gatherings, and team-based community service opportunities will serve to strengthen the communicative relationships within teams.

Conclusion

In this increasingly complex environment, leaders at all levels of the organization should focus attention and resources on what drives change in healthcare – the work of nurses. One influencer of that work is communication. Communication is such a prevalent component of the work of nursing yet little attention has been given to its role in supporting an organization's goals. One aspect of communication includes the relationships that are developed when communication is perceived to be effective. This study's findings suggest that when nurses positively perceive NM communication, they engage and buy-in to organizational initiatives that enhance PEC. This buy-in resulting from strong communicative relationships has extrinsic value given the role of PEC in value-based purchasing. It also has intrinsic value, as it supports both satisfied patients and satisfied nurses.

There are specific actions NMs should take so that nurses more positively perceive NM communication and increase their likelihood of buying-in to organizational initiatives. These actions require thoughtful assessment of how to integrate them into practice. Building strong communicative relationships is not a task one accomplishes by checking a box on a task list; rather, these relationships are developed when nurses believe their manager to be thoughtful and intentional in his or her approach to understanding and supporting their work and empowering them to own their professional practice through staff-led decision making.

This study adds to the limited body of nursing knowledge of how NMs' communicative relationships with nurses influences nurses' buy-in to initiatives to enhance PEC. The study also draws attentions to the fact that communication matters in healthcare. By exploring how communication relates to outcomes and taking action in support of strong communicative

relationships, leaders in healthcare organizations will place themselves at the forefront of leading change in a complex healthcare environment.

References

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French-Bravo, M., Nelson-Brantley, H., & Williams, K. (2019). *The power of communication: The nurse manager's capacity to influence the environment in which patients experience care through communication with nurses.* Manuscript in preparation.

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Giddens, A. (1984). *The constitution of society*. Berkeley, CA: University of California Press.

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Appendix A

Letter of Invitation to Chief Nursing Officer

Dear (CNO name):

Your hospital is being invited to participate in a study to understand how a nurse's perception of a nurse manager's communication relates to that nurse's buy-in to your hospital's initiatives to enhance patients' experiences with care, also referred to as patient satisfaction. The study will be conducted by Matthew French-Bravo, PhD student at the University of Kansas School of Nursing, under the direction of Dr. Kristine Williams and Dr. Heather Nelson-Brantley. Information obtained from this study will be used to provide recommendations to nurse managers specific to how they may adapt their communication so that nurses may be more willing to buy-in to initiatives to enhance patients' experiences with care.

The study will include in-person or phone individual interviews with nurses who work in medical, surgical, or combination medical and surgical non-intensive care units. Interviews will take place at a location of the nurse's choosing. Interviews will be conducted in English and will be audio recorded for transcription.

Participation is voluntary. Participants will be informed that they may withdraw their participation at any time, for any reason, without reprisal. Pseudonyms will be used to protect each participant's anonymity. Interviews are anticipated to take approximately one hour to complete and participants may be contacted after the interview to review the interview transcript and provide clarifying information. With your permission, observations of nurse and nurse manager interactions will take place during unit staff meetings throughout the study data collection period.

I welcome questions you may have about the general study objectives, your nurses' participation in the study, or the requested observations of your nurses and nurse managers. You may reach me directly at mfrench-bravo@kumc.edu or 316-768-1700. You may also reach Dr. Kristine Williams at kwilliams1@kumc.edu or Dr. Heather Nelson-Brantley at hnelson-brantley@kumc.edu.

Thank you for your consideration of this study.

Respectfully,

Matthew French-Bravo, MSN, RN
PhD Student, University of Kansas School of Nursing

Appendix B

CNO Email Communication

From: **Matthew French-Bravo** [redacted]
Subject: Re: KUMC School of Nursing PhD Candidate Introduction/Research Request
Date: July 6, 2018 at 6:39 PM
To: [redacted]
Cc: [redacted]

[redacted] thank you for your time and for your willingness to partner with me on my research. I enjoyed our conversation.

[redacted] I look forward to collaborating with you and your team. Please let me know how best to schedule time with you after you have an opportunity to speak with [redacted]

Again, thank you both!

Matt

On Jul 5, 2018, at 5:45 PM, [redacted] wrote:

> Hi Matt,
>
> I'm so glad we had the opportunity to visit earlier today. I'm copying [redacted] (as we discussed) on this note. I'll share a summary of our conversation with [redacted] next week when we have a change to connect.
>
> Thanks,
> [redacted]
>
> **From:** Matthew French-Bravo
> **Sent:** Wednesday, June 20, 2018 3:45 PM
> **To:** [redacted]
> **Cc:** [redacted]
> **Subject:** Re: KUMC School of Nursing PhD Candidate Introduction/Research Request
>
> [redacted]
>
> Thank you very much! I'm excited to speak with you and appreciate the opportunity. I've left a message for [redacted] and she and I will coordinate a time that works best for you.
>
> Again, thank you!
>
> Matt

Appendix C

Letter of Invitation to Nurse Manager

Dear (Nurse Manager name):

Your hospital's Chief Nursing Officer has agreed to your hospital's participation in a study to understand how a nurse's perception of a nurse manager's communication relates to that nurse's buy-in to your hospital's initiatives to enhance patients' experiences with care, also referred to as patient satisfaction. I invite you and your nurses to participate in this study. The study will be conducted by Matthew French-Bravo, PhD student at the University of Kansas School of Nursing, under the direction of Dr. Kristine Williams and Dr. Heather Nelson-Brantley. Information obtained from this study will be used to provide recommendations to you and your nurse manager colleagues specific to how nurse managers may adapt their communication so that nurses may be more willing to buy-in to initiatives to enhance patients' experiences with care.

The study will include in-person or phone individual interviews with nurses who work in medical, surgical, or combination medical and surgical non-intensive care units. Interviews will take place at a location of the nurse's choosing. Interviews will be conducted in English and will be audio recorded for transcription.

Participation is voluntary. Participants will be informed that they may withdraw their participation at any time, for any reason, without reprisal. Pseudonyms will be used to protect each participant's anonymity. Interviews are anticipated to take approximately one hour to complete and participants may be contacted after the interview to review the interview transcript and provide clarifying information. With your permission and arranged with your schedule, I also request the opportunity to observe one or more of your scheduled staff meetings to observe interactions between you and your nurses.

Your involvement includes: identifying eligible nurses (those who have worked in the unit for 3 or more months, are full-time or part-time employees [no less than 20 worked hours per week on average], spend 50% or more of their time in direct patient care, and are not charge nurses or serve in a similar supervisory capacity), emailing eligible nurses the attached Letter of Invitation to Nurses and Research Consent Form using the attached Nurse Manager Email Template to Nurses, and providing permission for researcher observation of staff meetings.

I welcome questions you may have about the general study objectives, your nurses' participation in the study, or the requested observations during your scheduled staff meetings. You may reach me directly at mfrench-bravo@kumc.edu or 316-768-1700. You may also reach Dr. Kristine Williams at kwilliams1@kumc.edu or Dr. Heather Nelson-Brantley at hnelson-brantley@kumc.edu.

Thank you for your consideration of this study.
Respectfully,
Matthew French-Bravo, MSN, RN
PhD Student, University of Kansas School of Nursing

Appendix D

Nurse Manager Email Template to Nurses

Team members:

Nurses in our unit are being invited to participant in a research study conducted by Matthew French-Bravo, PhD Student, University of Kansas School of Nursing, and researcher supervisors Dr. Kristine Williams and Dr. Heather Nelson-Brantley, University of Kansas School of Nursing.

The attached Letter of Invitation and Research Consent Form contain details of the study, eligibility criteria, and directions should you choose to participate. Participation is voluntary and I will not be notified if you participate or do not participate.

Please direct all research-related questions to the researchers via the contact information provided in the attached documents.

Thank you for your consideration of this nursing research study.

<Nurse Manager Name>

Appendix E

Letter of Invitation to Nurses

Dear colleague-

Your hospital's Chief Nursing Officer and unit nurse manager have agreed to your unit's participation in a study to understand how a nurse's perception of a nurse manager's communication relates to that nurse's buy-in to your hospital's initiatives to enhance patients' experiences with care, also referred to as patient satisfaction. I invite you to participate in this study. The study will be conducted by Matthew French-Bravo, PhD student at the University of Kansas School of Nursing, under the direction of Dr. Kristine Williams and Dr. Heather Nelson-Brantley. Information obtained from this study will be used to provide recommendations to nurse managers specific to how nurse managers may adapt their communication so that nurses may be more willing to buy-in to initiatives to enhance patients' experiences with care.

Your nurse manager has identified that you have worked in the unit for 3 or more months, are a full-time or part-time employee (no less than 20 worked hours per week on average), spend 50% or more of your time in direct patient care, and are not a charge nurse or serve in a similar supervisory capacity. If you do not meet these criteria, please let the researcher know and you will not be included in the study.

The study will include an in-person or phone interview. Interviews will take place at a location of your choosing, preferably a location that is quiet and supports confidentiality. Interviews will be conducted in English and will be audio recorded for transcription.

Your participation is voluntary. You may withdraw your participation at any time, for any reason, without reprisal. Pseudonyms will be used to protect your anonymity and results will be aggregated at the unit level. Your nurse manager will not be informed should you choose to participate or choose not to participate. Interviews are anticipated to take approximately one hour to complete and you may be contacted after the interview to review the interview transcript and provide clarifying information.

I welcome questions you may have about the general study objectives or your participation in the study. You may reach me directly at mfrench-bravo@kumc.edu or 316-768-1700. You may also reach Dr. Kristine Williams at kwilliams1@kumc.edu or Dr. Heather Nelson-Brantley at hnelson-brantley@kumc.edu.

A copy of the Research Consent Form is attached.

If you would like to participate in the study, please contact me via email (mfrench-bravo@kumc.edu) or via phone (316-768-1700) at your earliest convenience.

Thank you for your consideration of this study.
Respectfully,
Matthew French-Bravo, MSN, RN
PhD Student, University of Kansas School of Nursing

Appendix F

Semi-structured Interview Guide

Primary Questions

- Tell me about hospital or unit initiatives to enhance patients' experiences with care, also known as patient satisfaction? (Probe: Some examples could include hourly rounding, nurse bedside shift report, or multidisciplinary rounding. Does your unit participate in these types of initiatives or others that are similar?)
- Tell me about a time when your manager communicated with you about one of those initiatives. (Probe: Are there other examples that come to mind?)
- How did your nurse manager communicate that message?
- What other messages have you heard from your nurse manager about initiatives to enhance patients' experiences with care?
- Tell me about what you thought or felt as you received that communication from your nurse manager.
- Tell me about conversations you have with your peers specific to communication you receive from your nurse manager.
- In what way(s), if any, did your participation in initiatives to enhance patients' experiences with care change because of communication you received from your nurse manager?
- In what way(s), if any, did your participation in initiatives to enhance patients' experiences change because of conversations you had with your peers?
- How important is your manager's communication to your daily work?
- Describe a situation during which your manager's communication with you motivated you to change your attitude or behavior about an initiative.
- Describe a situation during which your manager's communication with you did not motivate you to change your attitude or behavior about an initiative.
- Is there anything you would like to share that we have not already discussed?

Appendix G

Demographic Questionnaire

What is your age? Researcher assigned pseudonym _____

- Under 18 years old
- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

What is your ethnicity?

- White
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian / Pacific Islander
- Other

What is your gender?

- Male
- Female
- Transgender
- Other (specify) _____
- Prefer not to say

How many years have you been a nurse?

- 0 to 4 years
- 5 to 10 years
- 11 to 15 years
- 16 to 20 years
- More than 20 years

What is the highest degree or level of school you have completed?

- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Doctorate degree

Appendix H

Interview Consent Form

Dear Nurse-

We are Matthew French-Bravo, PhD Student, University of Kansas School of Nursing, and researcher supervisors Dr. Kristine Williams and Dr. Heather Nelson-Brantley, University of Kansas School of Nursing. We are contacting you because you are a nurse who takes care of patients, works in a unit that undertakes initiatives to enhance patients' experiences with care (also referred to as patient satisfaction), and receives communication from your nurse manager. We are recruiting research participants to help us to explore how nurses' perceptions of nurse manager communication relate to nurses' buy-in to initiatives to enhance patients' experiences with care. Participation involves completing an in-person or phone recorded interview that will take about 60 minutes.

In addition to the interview questions, we will collect demographic data including age, ethnicity, gender, years you have been a nurse, and the highest degree or level of school you have completed. The treatment of the information will be through the use of pseudonyms known only to the researchers. Additionally, audio recordings will be destroyed after a professional transcriptionist transcribes them. You are free to give only the information you choose.

There are no personal benefits or risks to participating in this study. Participation is voluntary, and you can stop participating in the interview at any time. Your nurse manager will *not* be notified if you choose to participate or if you choose not to participate. Your choice to participate or decline to participate in this study will have no impact on your employment.

If you have any questions, please contact Matthew French-Bravo (mfrench-bravo@kumc.edu, 316-768-1700), or supervisors Dr. Kristine Williams (kwilliams1@kumc.edu) or Dr. Heather Nelson-Brantley (hnelson-brantley@kumc.edu). For questions about the rights of research participants, you may contact the KUMC Institutional Review Board (IRB) at 913-588-1240 or humansubjects@kumc.edu

Sincerely,

Matthew French-Bravo, MSN, RN
PhD Student, University of Kansas School of Nursing

If you agree to be in the study please print, sign, and date below:

Printed name:_____

Signature:_____ Date:_____

Appendix I

Staff Meeting Introduction

I am Matthew French-Bravo, PhD Student, University of Kansas School of Nursing. I am conducting research to explore how nurses' perceptions of nurse manager communication relate to nurses' buy-in to initiatives to enhance patients' experiences with care. The purpose of my attendance at this staff meeting is to listen to the content of the meeting and observe attendee interactions with each other. The notes I take will be used to supplement data obtained from individual interviews with nurses in this and other hospital units. No identifying data are collected during observation sessions. If you have questions about my attendance at this staff meeting, or if you'd like more information about how you may be able to participate in the study, please see me after the meeting.